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(Original Signature of Member)

109TH CONGRESS
1ST SESSION

H. R. _____

To improve the health of minority individuals.

IN THE HOUSE OF REPRESENTATIVES

Mr. HONDA introduced the following bill; which was referred to the Committee
on _____

A BILL

To improve the health of minority individuals.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

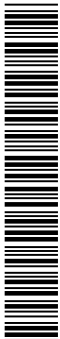
3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Healthcare Equality and Accountability Act”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings and purpose.

TITLE I—COVERAGE OF THE UNINSURED



2

Subtitle A—FamilyCare

- Sec. 101. Short title.
Sec. 102. Renaming of title XXI Program.

“TITLE XXI—FAMILYCARE PROGRAM

- Sec. 103. FamilyCare coverage of parents under the Medicaid Program and title XXI.
“Sec. 2111. Optional FamilyCare coverage of parents of targeted low-income children.
Sec. 104. Automatic enrollment of children born to title XXI parents.
Sec. 105. Optional coverage of children through age 20 under the Medicaid Program and title XXI.
Sec. 106. Allowing States to simplify rules for families.
Sec. 107. Demonstration programs to improve Medicaid and CHIP outreach to homeless individuals and families.
Sec. 108. Additional CHIP revisions.
Sec. 109. Coordination of title XXI with the maternal and child Health Program.

Subtitle B—State option to provide coverage for all residents with income at or below the poverty line

- Sec. 121. State option to provide coverage for all residents with income at or below the poverty line.

Subtitle C—Optional coverage of legal immigrants under the Medicaid Program and title XXI, and to extend eligibility to certain legal residents

- Sec. 131. Equal access to Health coverage for legal immigrants.
Sec. 132. Exception for citizens of freely associated States.

Subtitle D—Indian Healthcare funding

CHAPTER 1—GUARANTEED FUNDING

- Sec. 141. Guaranteed adequate funding for Indian Healthcare.
“Sec. 825. Funding.

CHAPTER 2—INDIAN HEALTHCARE PROGRAMS

- Sec. 145. Programs operated by Indian Tribes and Tribal organizations.
Sec. 146. Licensing.
Sec. 147. Authorization for emergency contract Health services.
Sec. 148. Prompt action on Payment of claims.
Sec. 149. Liability for Payment.
Sec. 150. Health services for ineligible persons.
Sec. 151. Definitions.
Sec. 152. Authorization of appropriations.

Subtitle E—Territories

- Sec. 161. Funding for territories.

Subtitle F—Migrant workers and farmworkers Health

- Sec. 171. Demonstration project regarding continuity of coverage of migrant workers and farmworkers under Medicaid and CHIP.



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Subtitle G—Expanded Access to Health Care

- Sec. 181. National Commission for Expanded Access to Health Care.
 Sec. 182. Institute of Medicine evaluation and report on Health care performance measures.

Subtitle H—FMAP reimbursement for Native Hawaiians

- Sec. 191. 100 percent FMAP for medical assistance provided to a Native Hawaiian through a federally-qualified Health Center or a Native Hawaiian Health care system under the Medicaid Program.

TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTHCARE

- Sec. 201. Amendment to the Public Health Service Act.

“TITLE XXIX—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTHCARE

- “Sec. 2900. Definitions.
 “Sec. 2901. Improving access to services for individuals with Limited English proficiency.
 “Sec. 2902. National Standards for culturally and linguistically appropriate services in Healthcare.
 “Sec. 2903. Robert T. Matsui Center for Cultural and Linguistic Competence in Healthcare.
 “Sec. 2904. Innovations in language access grants.
 “Sec. 2905. Research on language access.
 “Sec. 2906. Information about Federal Health programs for Limited English proficient populations.
 Sec. 202. Standards for language access services.
 Sec. 203. Federal reimbursement for culturally and linguistically appropriate services under the medicare, Medicaid and State Children’s Health Insurance Program.
 Sec. 204. Increasing understanding of Health literacy.
 Sec. 205. Report on Federal efforts to provide culturally and linguistically appropriate Healthcare services.
 Sec. 206. General Accounting Office report on impact of language access services.
 Sec. 207. Definitions.

TITLE III—HEALTH WORKFORCE DIVERSITY

- Sec. 301. Amendment to the Public Health Service Act.

“Subtitle A—Diversifying the Healthcare workplace

- “Sec. 2911. Report on workforce Diversity.
 “Sec. 2912. National Working Group on Workforce Diversity.
 “Sec. 2913. Technical Clearinghouse for Health workforce Diversity.
 “Sec. 2914. Evaluation of workforce Diversity initiatives.
 “Sec. 2915. Data collection and reporting by Health professional schools.
 “Sec. 2916. Support for Institutions committed to workforce Diversity.
 “Sec. 2917. Career development for scientists and researchers.
 “Sec. 2918. Career support for non-research Health professionals.
 “Sec. 2919. Research on the effect of workforce Diversity on quality.
 “Sec. 2920. Health disparities education Program.



- “Sec. 2920A. Cultural competence training for Healthcare professionals.
- Sec. 302. Health Careers Opportunity Program.
- Sec. 303. Program of excellence in Health professions education for underrepresented minorities.
- Sec. 304. Hispanic-Serving Health Professions Schools.
- “Sec. 742. Hispanic-Serving Health Professions Schools.
- Sec. 305. Health professions student loan fund; authorizations of appropriations regarding students from disadvantaged backgrounds.
- Sec. 306. National Health Service Corps; recruitment and fellowships for individuals from disadvantaged backgrounds.
- Sec. 307. Loan repayment Program of Centers for Disease Control and Prevention.
- Sec. 308. Cooperative agreements for online degree programs at schools of Public Health and schools of allied Health.
- “Sec. 743. Cooperative agreements for online degree programs.
- Sec. 309. Mid-career Health professions scholarship Program.
- “Sec. 744. Mid-career Health professions scholarship Program.
- Sec. 310. Strengthening and expanding rural Health provider networks.
- Sec. 311. National report on the preparedness of Health professionals to care for diverse populations.
- Sec. 312. Scholarship and fellowship programs.
- “Sec. 2920B. David Satcher Public Health and Health Services Corps.
- “Sec. 2920C. Louis Stokes Public Health Scholars Program.
- “Sec. 2920D. Patsy Mink Health and Gender Research Fellowship Program.
- “Sec. 2920E. Paul David Wellstone International Health Fellowship Program.
- “Sec. 2920F. Edward R. Roybal Healthcare Scholar Program.
- Sec. 313. Advisory Committee on Health Professions Training for Diversity.
- Sec. 314. Menair postbaccalaureate achievement Program.

TITLE IV—REDUCING DISEASE AND DISEASE-RELATED COMPLICATIONS

Subtitle A—Education and outreach

- Sec. 401. Preventive Health services block grants; use of allotments.
- Sec. 402. Indigenous, racial and ethnic approaches to community Health.
- Sec. 403. Grants to promote positive Health behaviors in women.
- “Sec. 399O. Grants to promote positive Health behaviors in women.
- Sec. 404. Provisions regarding National Asthma Education and Prevention Program of national heart, lung, and Blood Institute.
- Sec. 405. Asthma-related activities of Centers for Disease Control and Prevention.
- Sec. 406. Grants for community outreach regarding asthma information, education, and services.
- Sec. 407. Action plans of local educational agencies regarding asthma.
- Sec. 408. Programs of Centers for Disease Control and Prevention.
- “Sec. 317H. Diabetes in children and youth.
- Sec. 409. Research with respect to uterine fibroids.
- Sec. 410. Information and education with respect to uterine fibroids.

Subtitle B—Research and training

- Sec. 431. Innovative chronic disease management programs.
- Sec. 432. Research funding for autoimmune disease in minority populations.



“Sec. 490E–1. Research funding for autoimmune disease in minority populations.

Sec. 433. Research on effective messages for combatting stigma.

Subtitle C—Innovative treatment modalities and services delivery models

Sec. 441. Guidelines for disease screening for minority patients.

Sec. 442. Cancer reduction.

“Subtitle B—Reducing disease and disease-related complications

“Sec. 2921. Cancer prevention and treatment for underserved minority or other populations.

Sec. 443. Monitoring the quality of and disparities in diabetes care.

“Sec. 904. Areas of special emphasis.

Sec. 444. Diabetes prevention, treatment, and control.

Sec. 445. Genetics of diabetes.

“Sec. 430A. Genetics of diabetes.

Sec. 446. Research and training on diabetes in underserved and minority populations.

“Sec. 434B. Research on diabetes in underserved and minority populations.

Sec. 447. Authorization of appropriations.

“Sec. 434C. Authorization of appropriations.

Sec. 448. Prevention and control of sexually transmitted diseases.

Sec. 449. Model community diabetes and chronic disease care and prevention among Pacific Islanders and Native Hawaiians.

“Sec. 399P. Model community diabetes and chronic disease care and prevention among Pacific Islanders and Native Hawaiians.

Sec. 450. Grants to improve the provision of dental services under Medicaid and SCHIP.

“Sec. 511. Grants to improve the provision of dental services under Medicaid and SCHIP.

Sec. 451. State option to provide wrap-around SCHIP coverage to children who have other Health coverage.

Sec. 452. Grants to improve the provision of dental Health services through community Health Centers and public Health departments.

“Sec. 329. Grant Program to expand the availability of services.

Sec. 453. Priority substance abuse treatment needs of regional and national significance.

Sec. 454. Fetal Alcohol Syndrome.

“Sec. 2922. Fetal Alcohol Syndrome.

Sec. 455. HIV/AIDS reduction.

“Sec. 2923. HIV/AIDS reduction in the minority community.

Sec. 456. Systems for heart disease and stroke.

“Sec. 2924. Heart disease.

“Sec. 2925. Stroke education campaign.

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Sec. 463. Advisory Council for the Elimination of Tuberculosis.

Sec. 464. National Program for tuberculosis elimination.

Sec. 465. Inclusion of inpatient hospital services for the treatment of tb-infected individuals.



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Subtitle E—Miscellaneous provisions

- Sec. 471. Health empowerment zones.
- Sec. 472. Overweight and obesity prevention and treatment.
- Sec. 473. Border Health grants.
- Sec. 474. United States-Mexico Border Health Commission Act amendments.
 - “Sec. 9. Authorization of appropriations.
- Sec. 475. Prevention and control of injuries.

TITLE V—DATA COLLECTION AND REPORTING

- Sec. 501. Amendment to the Public Health Service Act.

- “Subtitle C—Strengthening data collection, improving data analysis, and expanding data reporting

- “Sec. 2931. Data on race, ethnicity, and primary language.
- “Sec. 2932. Provisions relating to Native Americans.
- Sec. 502. Collection of race and ethnicity data by the Social Security Administration.
 - “Sec. 1150A. Collection of race and ethnicity data by the Social Security Administration.
- Sec. 503. Revision of HIPAA claims Standards.
- Sec. 504. National Center for Health Statistics.
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TITLE VI—ACCOUNTABILITY

Subtitle A—General provisions

- Sec. 601. Report on workforce Diversity.
- Sec. 602. Federal Agency plan to eliminate disparities and improve the Health of minority populations.
- Sec. 603. Accountability within the Department of Health and Human Services.

- “Subtitle D—Strengthening accountability

- “Sec. 2941. Elevation of the Office of Civil Rights.
- “Sec. 2942. Establishment of Health Program offices for Civil Rights within Federal Health and human services agencies.
- Sec. 604. Office of Minority Health.
- Sec. 605. Establishment of the Indian Health Service as an Agency of the public Health Service.
- Sec. 606. Establishment of individual offices of Minority Health within agencies of public Health Service.
 - “Sec. 1707A. Individual offices of Minority Health within public Health Service.
- Sec. 607. Office of Minority Health at the Centers for Medicare and Medicaid Services.
- Sec. 608. Office of Minority Affairs at the Food and Drug Administration.
 - “Sec. 908. Office of Minority Affairs.
- Sec. 609. Safety and effectiveness of drugs with respect to racial and ethnic background.
 - “Sec. 505C. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 610. United States Commission on Civil Rights.



Sec. 610A. Sense of Congress concerning full funding of activities to eliminate racial and ethnic Health disparities.

Subtitle B—Minority Health and Genomics Commission

Sec. 611. Short title.
Sec. 612. Minority Health and Genomics Commission.
Sec. 613. Report.
Sec. 614. Membership.
Sec. 615. Powers of Commission.
Sec. 616. Termination.

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Sec. 622. Environmental justice responsibilities of Federal agencies.
Sec. 623. Interagency environmental justice Working Group.
Sec. 624. Federal Agency strategies.
Sec. 625. Federal Environmental Justice Advisory Committee.
Sec. 626. Human Health and environmental research, data collection and analysis.

TITLE VII—STRENGTHENING HEALTH INSTITUTIONS THAT
PROVIDE HEALTHCARE TO MINORITY POPULATIONS

Subtitle A—General provisions

Sec. 701. Amendment to the Public Health Service Act.

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“CHAPTER 1—GENERAL PROGRAMS

“Sec. 2951. Grant support for quality improvement initiatives.
“Sec. 2951A. Centers of excellence.
“Sec. 2952B. Consultation, construction and renovation of American Indian and Alaska Native facilities; reports.
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“Sec. 2952. Payments to Healthcare facilities.
“Sec. 2952A. Application for assistance.
“Sec. 2952B. Public Service responsibilities.
“Sec. 2952C. Health Safety Net Infrastructure Trust Fund.
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“Sec. 2953. Provision of loan guarantees to safety net Healthcare facilities.
“Sec. 2953A. Eligible loans.
“Sec. 2953B. Guarantee allotments.
“Sec. 2953C. Terms and conditions of loan guarantees.



“Sec. 2953D. Premiums for loan guarantees.

“Sec. 2953E. Procedures in the event of loan default.

“SUBCHAPTER C—GRANTS FOR URGENT CAPITAL NEEDS

“Sec. 2956. Provision of grants.

“Sec. 2956B. Eligible projects.

Sec. 702. Establishment of Alejandro Garcia National Center for Social Work Research.

“PART J—ALEJANDRO GARCIA NATIONAL CENTER FOR SOCIAL WORK RESEARCH

“Sec. 597. Purpose of Center.

“Sec. 597A. Specific authorities.

“Sec. 597B. Advisory Council.

“Sec. 597C. Biennial report.

“Sec. 597D. Quarterly report.

“Sec. 597E. Authorization of appropriations.

Sec. 703. Annie Dodge Wauneka and Susan Laflesche-Picotte Native American Health and Wellness Foundation.

“TITLE VIII—ANNIE DODGE WAUNEKA AND SUSAN LAFLESCHE-PICOTTE NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

“Sec. 801. Definitions.

“Sec. 802. Annie Dodge Wauneka and Susan Laflesche-Picotte Native American Health and Wellness Foundation.

“Sec. 803. Administrative services and support.

Subtitle B—Rural and underserved urban America telehealth programs

Sec. 711. Increasing types of originating telehealth sites and facilitating the provision of telehealth services across State lines.

Sec. 712. Strengthening telehealth services in rural and underserved urban America.

“Sec. 330M. Integrative eldercare telehealth demonstration project.

“Sec. 330N. American Indian and Alaska Native telehealth demonstration project.

“Sec. 330O. Oral Health telehealth demonstration project.

Sec. 713. Joint Working Group on Telehealth.

TITLE VIII—MISCELLANEOUS PROVISIONS

Sec. 801. Definitions.

Sec. 802. Davis-Bacon Act.

1 SEC. 2. FINDINGS AND PURPOSE.

2 (a) FINDINGS.—Congress makes the following find-
3 ings:

4 (1) Despite significant advances in public
5 health and health care, the health status of racial



1 and ethnic minority populations continues to lag be-
2 hind that of the white population.

3 (2) The United States is becoming increasingly
4 diverse. According to the 2000 United States Cen-
5 sus, African Americans, American Indians and Alas-
6 ka Natives, Asians, Hispanics, and Native Hawai-
7 ians and other Pacific Islanders comprise 30 percent
8 of the United States population. Racial and ethnic
9 minorities are expected to comprise 40 percent of
10 the United States population by 2030.

11 (3) To improve the health care of racial and
12 ethnic minorities and to reduce and eliminate dis-
13 parities in health care and health outcomes, the fol-
14 lowing issues must be addressed:

15 (A) NEED FOR INSURANCE COVERAGE.—

16 (i) Disparities in health status can be
17 attributed largely to underlying differences
18 in socioeconomic status and insurance cov-
19 erage. Minorities are at a greater risk of
20 being uninsured than their white counter-
21 parts. Lack of health insurance has con-
22 sistently been associated with worse health
23 outcomes.

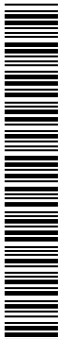
24 (ii) Even after adjusting for dif-
25 ferences in socioeconomic and insurance



1 status, however, racial and ethnic health
2 and health care disparities remain.

3 (iii) Through treaties and Federal
4 statutes, the Federal Government has es-
5 tablished a trust responsibility to provide
6 health care to American Indians and Alas-
7 ka Natives. In the Indian Health Amend-
8 ments of 1992, Congress specifically
9 pledged to “assure the highest possible
10 health status for Indians and urban Indi-
11 ans and to provide all resources necessary
12 to effect that policy.” Despite those com-
13 mitments, the unmet health needs of
14 American Indians and Alaska Natives re-
15 main alarmingly severe and their health
16 status is far below the health status of the
17 general population of the United States.
18 The critical shortfall of funding for the In-
19 dian Health Service is a major source of
20 this problem.

21 (iv) At least 26,000,000 children in
22 the United States lack dental coverage.
23 These children include06many from “work-
24 ing poor families” who cannot access
25 SCHIP because they have some medical



1 coverage. White children are 1.7 times
2 more likely to have private dental coverage
3 than non-white children.

4 (v) As few as 7 States continue to
5 provide reasonably comprehensive dental
6 care to poor adults through Medicaid.
7 About half the States provide no dental
8 coverage or provide emergency services
9 only.

10 (B) NEED FOR CULTURALLY AND LINGUIS-
11 TICALLY APPROPRIATE CARE.—

12 (i) Limited English proficiency ad-
13 versely affects the care of many racial and
14 ethnic minority patients. The lack of avail-
15 able interpretation and translation services
16 or bilingual providers contributes to racial
17 and ethnic disparities in health and health
18 care. The Federal Government provides
19 and funds an array of services that should
20 be made accessible to eligible persons who
21 are not proficient in the English language.

22 (ii) Title VI of the Civil Rights Act of
23 1964 (42 U.S.C. 2000d et seq.) prohibits
24 discrimination on the basis of race, color,
25 and national origin in programs and activi-



1 ties receiving Federal financial assistance.
2 Discrimination on the basis of primary lan-
3 guage has consistently been interpreted as
4 discrimination on the basis of national ori-
5 gin.

6 (iii) The provision of effective lan-
7 guage services has been shown to improve
8 care for limited English proficient (re-
9 ferred to in this section as “LEP”) pa-
10 tients by increasing patient satisfaction,
11 access to care, compliance with rec-
12 ommended medical advice, and appropriate
13 utilization.

14 (iv) A 2002 study by the Office of
15 Management and Budget found that lan-
16 guage assistance services can substantially
17 improve the health and quality of life of
18 LEP individuals and their families, in-
19 crease the efficiency of distribution of gov-
20 ernment services to LEP individuals, and
21 measurably increase the effectiveness of
22 public health and safety programs.

23 (v) The same study estimated that
24 language translation services would only



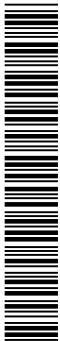
1 increase the cost of the average health care
2 visit by less than one percent.

3 (vi) Increasing racial and ethnic diver-
4 sity among health professionals is vitally
5 important because evidence indicates that
6 diversity is associated with improved access
7 to care for racial and ethnic minority pa-
8 tients, greater patient satisfaction, and
9 better educational experiences for health
10 profession students, among many other
11 benefits.

12 (C) NEED FOR HEALTH WORKFORCE DI-
13 VERSITY.—

14 (i) Research has demonstrated that
15 minority health professionals dramatically
16 increase access to care for minority pa-
17 tients and improve the quality of care that
18 they receive. African Americans, American
19 Indians and Alaska Natives, Hispanics,
20 Native Hawaiians and other Pacific Island-
21 ers, and Southeast Asians are significantly
22 underrepresented in the health professions,
23 exacerbating health disparities.

24 (ii) Minority physicians are more like-
25 ly than white physicians to serve minority



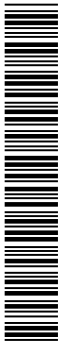
1 populations. Nearly 40 percent of all mi-
2 nority medical school graduates will prac-
3 tice medicine in underserved areas, com-
4 pared to 10 percent of their white col-
5 leagues.

6 (iii) Minorities often report experi-
7 ences with discrimination when seeking
8 health care.

9 (iv) There is substantial evidence to
10 demonstrate that race concordance be-
11 tween physicians and patients increases
12 patient satisfaction and participation in
13 health decisionmaking.

14 (v) Minority health care providers can
15 bridge linguistic, cultural, and other bar-
16 riers that hamper access to care.

17 (vi) African Americans, Hispanics,
18 and American Indians remain severely
19 underrepresented in health professions
20 schools. African Americans and Hispanics
21 constitute 20 percent and 16 percent, re-
22 spectively, of the students in public health
23 and baccalaureate nursing programs, and
24 less than 15 percent of students in all
25 other health professions.



1 (vi) The number of minorities enroll-
2 ing in health professional schools has re-
3 mained stagnant. For example, in 1994,
4 1,307 African American and 1,090 His-
5 panic students enrolled in American med-
6 ical colleges. In 2000, the figures were es-
7 sentially unchanged at 1,307 African
8 American and 1,033 Hispanic students.

9 (vii) While the need for a racially and
10 ethnically diverse workforce is clear, the
11 practitioners, faculty, and students of the
12 fields of nursing, medicine, dentistry, psy-
13 chology, social work, behavioral science,
14 and health education have yet to reflect the
15 diversity of the Nation.

16 (viii) In 2003, only 2 percent of prac-
17 ticing dentists and 3 percent of dental hy-
18 gienists were African-American, and only 4
19 percent of practicing dentists and 1 per-
20 cent of hygienists were Hispanic.

21 (ix) Underrepresented minority re-
22 cruitment into dental education is a seri-
23 ous problem.⁰⁶ In 2003, the first-year en-
24 rollment of underrepresented minority stu-
25 dents in dental school was only 11.6 per-

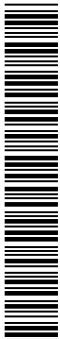


1 cent of the total first year enrollment.06 In
2 1990, the percentage of underrepresented
3 minority students in the first year class
4 was 13.8 percent of the total first year en-
5 rollment.06

6 (x) Given the fact that the patients of
7 Black dentists are 61.8 percent black and
8 the patients of Hispanic dentists are 45.4
9 percent Hispanic, increasing minority en-
10 rollment is an immediate and practical ap-
11 proach to addressing the problem. Only
12 10.5 percent of Black patients are seen by
13 white dentists.

14 (D) NEED FOR REDUCTION OF DISEASE
15 OCCURRENCE AND DISEASE-RELATED COM-
16 PLICATIONS AMONG MINORITIES.—

17 (i) Despite notable progress in the
18 overall health of the Nation, there are con-
19 tinuing disparities in the burden of illness
20 and death experienced by minorities com-
21 pared to the United States population as a
22 whole. Minority populations are dispropor-
23 tionately impacted by acute and chronic
24 diseases.



1 (ii) In 2000, 6 of the 10 leading
2 causes of death for all age groups in this
3 country were behaviorally based. In addi-
4 tion, many modifiable behavioral factors
5 are now known to increase an individual's
6 risk for disease and physical disability, rep-
7 resenting the largest amount of prevent-
8 able healthcare expenses.

9 (iii) Despite suffering a greater bur-
10 den of acute and chronic disease, minori-
11 ties are less likely to receive needed health
12 care. Numerous studies have documented
13 that minorities receive less preventive care,
14 medical therapy, and surgical interven-
15 tions.

16 (iv) Culturally appropriate, commu-
17 nity-driven programs are essential to elimi-
18 nating health disparities. To be successful,
19 these programs need to be based on sound
20 prevention research and supported by new
21 and innovative partnerships among govern-
22 ments, businesses, faith-based organiza-
23 tions, and communities.

24 (v) Parents reported seeking care for
25 relief of their child's pain for 10 percent of



1 white children, 16 percent of Black chil-
2 dren, and 17 percent of Hispanic children.
3 Parents of American Indian and Alaska
4 Native schoolchildren report that one third
5 miss school because of dental pain each
6 year. They also report that 1 in 4 avoid
7 laughing or smiling and 1 in 5 avoid meet-
8 ing other people because of the way their
9 teeth look.

10 (vi) Five-year survival statistics for
11 Blacks are poorer at 33 percent versus 55
12 percent for whites.

13 (vii) Hispanic adults are twice as like-
14 ly, Black adults 3 times as likely, and
15 Asian adults 4 times as likely as whites to
16 report missed work or missed school be-
17 cause of a dental problem.

18 (E) NEED FOR MINORITY HEALTH DATA
19 COLLECTION AND REPORTING.—

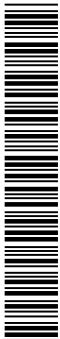
20 (i) Efforts to study disparities in
21 health and health care for minorities have
22 been hampered by the lack of available
23 data on race, ethnicity, and primary lan-
24 guage.



1 (ii) Data collection, analysis, and re-
2 porting by race, ethnicity, and primary lan-
3 guage is permissible under the law and
4 necessary to assure equity and non-
5 discrimination in the quality of health care
6 services. Collection, analysis, and reporting
7 of such data is authorized under Title VI
8 of the Civil Rights Act of 1964 (42 U.S.C.
9 2000d et seq.). Such collection, analysis,
10 and reporting should be conducted with ap-
11 propriate privacy protections in place.

12 (F) NEED FOR GREATER ACCOUNTABILITY
13 IN GOVERNMENT INSTITUTIONS.—A number of
14 studies have shown that differences in health
15 care quality contribute to health disparities
16 among minority populations. These differences
17 may result from bias, stereotyping, and dis-
18 crimination. Government institutions must be
19 held accountable for the quality of health care
20 delivered to all patient populations and result-
21 ant health outcomes.

22 (G) NEED FOR EQUITABLE SOCIO-
23 ECONOMIC POLICIES.—Literature suggests that
24 equitable socioeconomic policies are needed to
25 improve the health status of racial and ethnic



1 minorities and economically disadvantaged pop-
2 ulations.

3 (H) NEED FOR STRENGTHENING HEALTH
4 INSTITUTIONS THAT PROVIDE CARE TO MINOR-
5 ITY POPULATIONS.—

6 (i) A small segment of health care in-
7 stitutions provide a disproportionate
8 amount of health care to minority popu-
9 lations.

10 (ii) Safety net institutions, including
11 public hospitals, community health centers
12 and community clinics, provide a dis-
13 proportionate share of health care to mi-
14 nority and underserved populations.

15 (iii) Financial stress, negative oper-
16 ating margins, and the overall burden of
17 caring for the uninsured and delivering
18 high-cost specialty care to the entire com-
19 munity place undue pressure on core safety
20 net providers. These providers are increas-
21 ingly challenged in their ability to meet the
22 day-to-day needs of their patients.

23 (b) PURPOSES.—It is the purpose of this Act to im-
24 prove the health and healthcare of minority populations



1 and to eliminate racial and ethnic disparities in health and
2 healthcare by—

3 (1) increasing access to health care for all pop-
4 ulations;

5 (2) expanding culturally and linguistically ap-
6 propriate health services for all populations;

7 (3) promoting health workforce diversity;

8 (4) supporting and expanding programs and ac-
9 tivities that will improve the prevention, diagnosis,
10 and management of disease in minority populations;

11 (5) enhancing racial, ethnic, and primary lan-
12 guage health data collection at the local, State, and
13 Federal level;

14 (6) ensuring accountability for the quality of
15 health care and health outcomes for minority popu-
16 lations; and

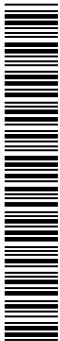
17 (7) strengthening the technical and financial re-
18 sources of the safety net institutions of the United
19 States.

20 **TITLE I—COVERAGE OF THE**
21 **UNINSURED**

22 **Subtitle A—FamilyCare**

23 **SEC. 101. SHORT TITLE.**

24 This subtitle may be cited as the “FamilyCare Act
25 of 2005”.



1 **SEC. 102. RENAMING OF TITLE XXI PROGRAM.**

2 (a) IN GENERAL.—The heading of title XXI of the
3 Social Security Act (42 U.S.C. 1397aa et seq.) is amended
4 to read as follows:

5 **“TITLE XXI—FAMILYCARE**
6 **PROGRAM”.**

7 (b) PROGRAM REFERENCES.—Any reference in any
8 provision of Federal law or regulation to “SCHIP” or
9 “State children’s health insurance program” under title
10 XXI of the Social Security Act shall be deemed a reference
11 to the FamilyCare program under such title.

12 **SEC. 103. FAMILYCARE COVERAGE OF PARENTS UNDER**
13 **THE MEDICAID PROGRAM AND TITLE XXI.**

14 (a) INCENTIVES TO IMPLEMENT FAMILYCARE COV-
15 ERAGE.—

16 (1) UNDER MEDICAID.—

17 (A) ESTABLISHMENT OF NEW OPTIONAL
18 ELIGIBILITY CATEGORY.—Section 1902(a)(10)
19 (A)(ii) of the Social Security Act (42 U.S.C.
20 1396a(a)(10)(A)(ii)) is amended—

21 (i) by striking “or” at the end of sub-
22 clause (XVII);

23 (ii) by adding “or” at the end of sub-
24 clause (XVIII); and

25 (iii) by adding at the end the fol-
26 lowing:



1 “(XIX) who are individuals de-
2 scribed in subsection (k)(1) (relating
3 to parents of categorically eligible chil-
4 dren);”.

5 (B) PARENTS DESCRIBED.—Section 1902
6 of the Social Security Act is further amended
7 by inserting after subsection (j) the following:

8 “(k)(1)(A) Individuals described in this paragraph
9 are individuals—

10 “(i) who are the parents of an individual who
11 is under 19 years of age (or such higher age as the
12 State may have elected under section 1902(l)(1)(D))
13 and who is eligible for medical assistance under sub-
14 section (a)(10)(A);

15 “(ii) who are not otherwise eligible for medical
16 assistance under such subsection or under a waiver
17 approved under section 1115 or otherwise (except
18 under section 1931 or under subsection
19 (a)(10)(A)(ii)(XIX)); and

20 “(iii) whose family income or resources exceeds
21 the effective income level or resource level applicable
22 under the State plan under part A of title IV as in
23 effect as of July 16, 1996, but does not exceed the
24 highest effective income or resource level (if any) ap-
25 plicable to a child in the family under this title.



1 “(B) In establishing an income eligibility level for in-
2 dividuals described in this paragraph, a State may vary
3 such level consistent with the various income levels estab-
4 lished under subsection (1)(2) in order to ensure, to the
5 maximum extent possible, that such individuals shall be
6 enrolled in the same program as their children.

7 “(C) An individual may not be treated as being de-
8 scribed in this paragraph unless, at the time of the individ-
9 ual’s enrollment under this title, the child referred to in
10 subparagraph (A)(i) of the individual is also enrolled
11 under this title or otherwise insured.

12 “(D) In this subsection, the term ‘parent’ includes
13 an individual treated as a caretaker for purposes of car-
14 rying out section 1931.

15 “(E) In this subsection, the term ‘effective income
16 level’ means the income level expressed as a percent of
17 the poverty line and considering applicable income dis-
18 regards.

19 “(2) The State shall provide for coverage of a parent
20 described in paragraph (1) or section 2111 of a child who
21 is covered under this title or title XXI under the same
22 title as the title as such child is covered. In the case of
23 a parent described in paragraph (1) who is also the parent
24 of a child who is eligible for child health assistance under
25 title XXI, the State may elect (on a uniform basis) to



1 cover all such parents under section 2111 or under this
2 title.”.

3 (C) ENHANCED MATCHING FUNDS AVAIL-
4 ABLE IF CERTAIN CONDITIONS MET.—Section
5 1905 of the Social Security Act (42 U.S.C.
6 1396d) is amended—

7 (i) in the fourth sentence of sub-
8 section (b), by striking “or subsection
9 (u)(3)” and inserting “, (u)(3), or (u)(4)”;
10 and

11 (ii) in subsection (u)—

12 (I) by redesignating paragraph
13 (4) as paragraph (6), and

14 (II) by inserting after paragraph
15 (3) the following:

16 “(4) For purposes of subsection (b) and section
17 2105(a)(1):

18 “(A) FAMILYCARE PARENTS.—The expendi-
19 tures described in this subparagraph are the expend-
20 itures described in the following clauses (i) and (ii):

21 “(i) PARENTS.—If the conditions described
22 in clauses (iii) and (iv) are met, expenditures
23 for medical assistance for parents described in
24 section 1902(k)(1) and for parents who would
25 be described in such section but for the fact



1 that they are eligible for medical assistance
2 under section 1931 or under a waiver approved
3 under section 1115.

4 “(ii) CERTAIN PREGNANT WOMEN.—If the
5 conditions described in clause (v) are met, ex-
6 penditures for medical assistance for pregnant
7 women described in subsection (n) or under sec-
8 tion 1902(l)(1)(A) in a family the income of
9 which exceeds the effective income level applica-
10 ble under subsection (a)(10)(A)(i)(III) or
11 (l)(2)(A) of section 1902 to a family of the size
12 involved as of January 1, 2006.

13 “(iii) CONDITIONS RELATING TO ENSURING
14 CHILDREN’S COVERAGE FOR ENHANCED MATCH
15 FOR PARENTS.—The conditions described in
16 this clause are the following:

17 “(I) The State has a State child
18 health plan under title XXI which (wheth-
19 er implemented under such title or under
20 this title) has an effective income level for
21 children that is at least 200 percent of the
22 poverty line.

23 “(II) Such State child health plan
24 does not limit the acceptance of applica-
25 tions, does not use a waiting list for chil-



1 dren who meet eligibility standards to
2 qualify for assistance, and provides bene-
3 fits to all children in the State who apply
4 for and meet eligibility standards.

5 “(III) Effective for determinations of
6 eligibility made on or after the date that is
7 1 year after the date of the enactment of
8 this clause, the application and renewal
9 procedures for individuals under 19 years
10 of age (or such higher age as the State has
11 elected under section 1902(l)(1)(D)) for
12 medical assistance under section
13 1902(a)(10)(A) are not be more restrictive
14 or burdensome than such procedures used
15 for children with higher income under the
16 State child health plan under title XXI.

17 “(iv) CONDITIONS RELATING TO MINIMUM
18 COVERAGE FOR PARENTS FOR ENHANCED
19 MATCH FOR PARENTS.—The conditions de-
20 scribed in this clause are the following:

21 “(I) The State does not apply an in-
22 come level for parents that is lower than
23 the effective income level (expressed as a
24 percent of the poverty line) that has been
25 specified under the State plan under title



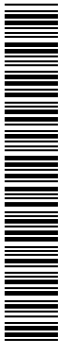
1 XIX (including under a waiver authorized
2 by the Secretary or under section
3 1902(r)(2)), as of January 1, 2006, to be
4 eligible for medical assistance as a parent
5 under this title.

6 “(II) The State plans under this title
7 and title XXI do not provide coverage for
8 parents with higher family income without
9 covering parents with a lower family in-
10 come.

11 “(v) CONDITIONS FOR ENHANCED MATCH
12 FOR CERTAIN PREGNANT WOMEN.—The condi-
13 tions described in this clause are the following:

14 “(I) The State has established an ef-
15 fective income eligibility level for pregnant
16 women under subsection (a)(10)(A)(i)(III)
17 or (l)(2)(A) of section 1902 that is at least
18 185 percent of the poverty line.

19 “(II) The State plans under this title
20 and title XXI do not provide coverage for
21 pregnant women described in subpara-
22 graph (A)(ii) with higher family income
23 without covering such pregnant women
24 with a lower family income.



1 “(III) The State does not apply an in-
2 come level for pregnant women that is
3 lower than the effective income level that
4 has been specified under the State plan
5 under subsection (a)(10)(A)(i)(III) or
6 (l)(2)(A) of section 1902, as of January 1,
7 2006, to be eligible for medical assistance
8 as a pregnant woman.

9 “(IV) The State satisfies the condi-
10 tions described in subclauses (I) and (II)
11 of clause (iii).

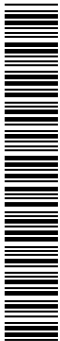
12 “(vi) DEFINITIONS.—For purposes of this
13 subsection:

14 “(I) The term ‘parent’ has the mean-
15 ing given such term for purposes of section
16 1902(k)(1).

17 “(II) The term ‘poverty line’ has the
18 meaning given such term in section
19 2110(c)(5).”.

20 (D) APPROPRIATION FROM TITLE XXI AL-
21 LOTMENT FOR CERTAIN MEDICAID EXPANSION
22 COSTS.—Section 2105(a) of the Social Security
23 Act (42 U.S.C. 1397ee(a)) is amended—

24 (i) in paragraph (1), by redesignating
25 subparagraphs (B) through (D) as sub-



1 paragraphs (C) through (E), respectively,
2 and by inserting after subparagraph (A)
3 the following new subparagraph:

4 “(B) for medical assistance that is attrib-
5 utable to expenditures described in section
6 1905(u)(4)(A);”; and

7 (ii) in paragraph (2), by adding at the
8 end the following new subparagraph:

9 “(E) Fifth, for expenditures for items de-
10 scribed in paragraph (1)(E).”.

11 (2) UNDER TITLE XXI.—

12 (A) FAMILYCARE COVERAGE.—Title XXI
13 of the Social Security Act (42 U.S.C. 1397aa et
14 seq.) is amended by adding at the end the fol-
15 lowing:

16 **“SEC. 2111. OPTIONAL FAMILYCARE COVERAGE OF PAR-**
17 **ENTS OF TARGETED LOW-INCOME CHILDREN.**

18 “(a) OPTIONAL COVERAGE.—Notwithstanding any
19 other provision of this title, a State may provide for cov-
20 erage, through an amendment to its State child health
21 plan under section 2102, of parent health assistance for
22 targeted low-income parents, health care assistance for
23 targeted low-income pregnant women, or both, in accord-
24 ance with this section, but only if—



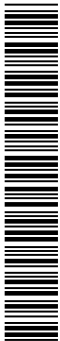
1 “(1) with respect to the provision of parent
2 health assistance, the State meets the conditions de-
3 scribed in clause (iii) of section 1905(u)(4)(A);

4 “(2) with respect to the provision of health care
5 assistance for pregnant women, the State meets the
6 conditions described in clause (iv) of section
7 1905(u)(4)(A); and

8 “(3) in the case of parent health assistance for
9 targeted low-income parents, the State elects to pro-
10 vide medical assistance under section
11 1902(a)(10)(A)(ii)(XIX), under section 1931, or
12 under a waiver under section 1115 to individuals de-
13 scribed in section 1902(k)(1)(A)(i) and elects an ef-
14 fective income level that, consistent with paragraphs
15 (1)(B) and (2) of section 1902(k), ensures to the
16 maximum extent possible, that such individuals shall
17 be enrolled in the same program as their children if
18 their children are eligible for coverage under title
19 XIX (including under a waiver authorized by the
20 Secretary or under section 1902(r)(2)).

21 “(b) DEFINITIONS.—For purposes of this title:

22 “(1) PARENT HEALTH ASSISTANCE.—The term
23 ‘parent health assistance’ has the meaning given the
24 term child health assistance in section 2110(a) as if



1 any reference to targeted low-income children were
2 a reference to targeted low-income parents.

3 “(2) PARENT.—The term ‘parent’ has the
4 meaning given the term ‘caretaker relative’ for pur-
5 poses of carrying out section 1931.

6 “(3) HEALTH CARE ASSISTANCE FOR PREG-
7 NANT WOMEN.—The term ‘health care assistance for
8 pregnant women’ has the meaning given the term
9 child health assistance in section 2110(a) as if any
10 reference to targeted low-income children were a ref-
11 erence to targeted low-income pregnant women.

12 “(4) TARGETED LOW-INCOME PARENT.—The
13 term ‘targeted low-income parent’ has the meaning
14 given the term targeted low-income child in section
15 2110(b) as if the reference to a child were deemed
16 a reference to a parent (as defined in paragraph (3))
17 of the child; except that in applying such section—

18 “(A) there shall be substituted for the in-
19 come level described in paragraph (1)(B)(ii)(I)
20 the applicable income level in effect for a tar-
21 geted low-income child;

22 “(B) in paragraph (3), January 1, 2006,
23 shall be substituted for July 1, 1997; and

24 “(C) in paragraph (4), January 1, 2006,
25 shall be substituted for March 31, 1997.



1 “(5) TARGETED LOW-INCOME PREGNANT
2 WOMAN.—The term ‘targeted low-income pregnant
3 woman’ has the meaning given the term targeted
4 low-income child in section 2110(b) as if any ref-
5 erence to a child were a reference to a woman dur-
6 ing pregnancy and through the end of the month in
7 which the 60-day period beginning on the last day
8 of her pregnancy ends; except that in applying such
9 section—

10 “(A) there shall be substituted for the in-
11 come level described in paragraph (1)(B)(ii)(I)
12 the applicable income level in effect for a tar-
13 geted low-income child;

14 “(B) in paragraph (3), January 1, 2006,
15 shall be substituted for July 1, 1997; and

16 “(C) in paragraph (4), January 1, 2006,
17 shall be substituted for March 31, 1997.

18 “(c) REFERENCES TO TERMS AND SPECIAL
19 RULES.—In the case of, and with respect to, a State pro-
20 viding for coverage of parent health assistance to targeted
21 low-income parents or health care assistance to targeted
22 low-income pregnant women under subsection (a), the fol-
23 lowing special rules apply:

24 “(1) Any reference in this title (other than in
25 subsection (b)) to a targeted low-income child is



1 deemed to include a reference to a targeted low-in-
2 come parent or a targeted low-income pregnant
3 woman (as applicable).

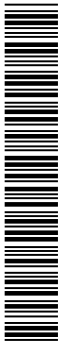
4 “(2) Any such reference to child health
5 assistance—

6 “(A) with respect to such parents is
7 deemed a reference to parent health assistance;
8 and

9 “(B) with respect to such pregnant women,
10 is deemed a reference to health care assistance
11 for pregnant women.

12 “(3) In applying section 2103(e)(3)(B) in the
13 case of a family (consisting of a parent and one or
14 more children) provided coverage under this section
15 or a pregnant woman provided coverage under this
16 section without covering other family members, the
17 limitation on total annual aggregate cost-sharing
18 shall be applied to such entire family or such preg-
19 nant woman, respectively.

20 “(4) In applying section 2110(b)(4), any ref-
21 erence to ‘section 1902(l)(2) or 1905(n)(2) (as se-
22 lected by a State)’ is deemed a reference to the ef-
23 fective income level applicable to parents under sec-
24 tion 1931 or under a waiver approved under section



1 1115, or, in the case of a pregnant woman, the in-
2 come level established under section 1902(1)(2)(A).

3 “(5) In applying section 2102(b)(3)(B), any
4 reference to children found through screening to be
5 eligible for medical assistance under the State med-
6 icaid plan under title XIX is deemed a reference to
7 parents and pregnant women.”.

8 (B) ADDITIONAL ALLOTMENT FOR STATES
9 PROVIDING FAMILYCARE.—

10 (i) IN GENERAL.—Section 2104 of the
11 Social Security Act (42 U.S.C. 1397dd) is
12 amended by inserting after subsection (c)
13 the following:

14 “(d) ADDITIONAL ALLOTMENTS FOR STATE PRO-
15 VIDING FAMILYCARE.—

16 “(1) APPROPRIATION; TOTAL ALLOTMENT.—
17 For the purpose of providing additional allotments
18 to States to provide FamilyCare coverage under sec-
19 tion 2111, there is appropriated, out of any money
20 in the Treasury not otherwise appropriated—

21 “(A) for fiscal year 2006, \$2,000,000,000;

22 “(B) for fiscal year 2007, \$2,000,000,000;

23 “(C) for fiscal year 2008, \$3,000,000,000;

24 and

25 “(D) for fiscal year 2009, \$3,000,000,000.



1 “(2) STATE AND TERRITORIAL ALLOTMENTS.—

2 “(A) IN GENERAL.—In addition to the al-
3 lotments provided under subsections (b) and
4 (c), subject to paragraphs (3) and (4), of the
5 amount available for the additional allotments
6 under paragraph (1) for a fiscal year, the Sec-
7 retary shall allot to each State with a State
8 child health plan approved under this title—

9 “(i) in the case of such a State other
10 than a commonwealth or territory de-
11 scribed in clause (ii), the same proportion
12 as the proportion of the State’s allotment
13 under subsection (b) (determined without
14 regard to subsection (f)) to 98.95 percent
15 of the total amount of the allotments
16 under such section for such States eligible
17 for an allotment under this subparagraph
18 for such fiscal year; and

19 “(ii) in the case of a commonwealth or
20 territory described in subsection (c)(3), the
21 same proportion as the proportion of the
22 commonwealth’s or territory’s allotment
23 under subsection (c) (determined without
24 regard to subsection (f)) to 1.05 percent of
25 the total amount of the allotments under



1 such section for commonwealths and terri-
2 tories eligible for an allotment under this
3 subparagraph for such fiscal year.

4 “(B) AVAILABILITY AND REDISTRIBUTION
5 OF UNUSED ALLOTMENTS.—In applying sub-
6 sections (e) and (f) with respect to additional
7 allotments made available under this subsection,
8 the procedures established under such sub-
9 sections shall ensure such additional allotments
10 are only made available to States which have
11 elected to provide coverage under section 2111.

12 “(3) USE OF ADDITIONAL ALLOTMENT.—Addi-
13 tional allotments provided under this subsection are
14 not available for amounts expended before October
15 1, 2007. Such amounts are available for amounts ex-
16 pended on or after such date for child health assist-
17 ance for targeted low-income children, as well as for
18 parent health assistance for targeted low-income
19 parents, and health care assistance for targeted low-
20 income pregnant women.

21 “(4) REQUIRING ELECTION TO PROVIDE COV-
22 ERAGE.—No payments may be made to a State
23 under this title from an allotment provided under
24 this subsection unless the State has made an elec-
25 tion to provide parent health assistance for targeted



1 low-income parents, or health care assistance for
2 targeted low-income pregnant women.”.

3 (ii) CONFORMING AMENDMENTS.—

4 Section 2104 of the Social Security Act
5 (42 U.S.C. 1397dd) is amended—

6 (I) in subsection (a), by inserting
7 “subject to subsection (d),” after
8 “under this section,”;

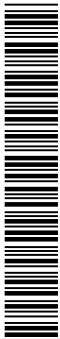
9 (II) in subsection (b)(1), by in-
10 serting “and subsection (d)” after
11 “Subject to paragraph (4)”; and

12 (III) in subsection (c)(1), by in-
13 serting “subject to subsection (d),”
14 after “for a fiscal year,”.

15 (C) NO COST-SHARING FOR PREGNANCY-
16 RELATED BENEFITS.—Section 2103(e)(2) of
17 the Social Security Act (42 U.S.C.
18 1397cc(e)(2)) is amended—

19 (i) in the heading, by inserting “**AND**
20 **PREGNANCY-RELATED SERVICES**” after
21 “**PREVENTIVE SERVICES**”; and

22 (ii) by inserting before the period at
23 the end the following: “and for pregnancy-
24 related services”.



1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection apply to items and services fur-
3 nished on or after October 1, 2007, whether or not
4 regulations implementing such amendments have
5 been issued.

6 (b) RULES FOR IMPLEMENTATION BEGINNING WITH
7 FISCAL YEAR 2007.—

8 (1) EXPANSION OF AVAILABILITY OF EN-
9 HANCED MATCH UNDER MEDICAID FOR PRE-CHIP
10 EXPANSIONS.—Paragraph (4) of section 1905(u) of
11 the Social Security Act (42 U.S.C. 1396d(u)), as in-
12 serted by subsection (a)(1)(C), is amended—

13 (A) by amending clause (ii) of subpara-
14 graph (A) to read as follows:

15 “(ii) CERTAIN PREGNANT WOMEN.—Ex-
16 penditures for medical assistance for pregnant
17 women under section 1902(l)(1)(A) in a family
18 the income of which exceeds the 133 percent of
19 the income official poverty line, but only if the
20 income level established under section
21 1902(l)(2) (or under a Statewide waiver under
22 section 1115) for pregnant women is 185 per-
23 cent of the income official poverty line.”; and

24 (B) by adding at the end the following:



1 “(B) CHILDREN IN FAMILIES WITH INCOME
2 ABOVE MEDICAID MANDATORY LEVEL NOT PRE-
3 VIOUSLY DESCRIBED.—The expenditures described
4 in this subparagraph are expenditures (other than
5 expenditures described in paragraph (2) or (3)) for
6 medical assistance made available to any child who
7 is eligible for assistance under section
8 1902(a)(10)(A) (other than under clause (i)) and
9 the income of whose family exceeds the minimum in-
10 come level required under subsection 1902(l)(2) (or,
11 if higher, the minimum level required under section
12 1931 for that State) for a child of the age involved
13 (treating any child who is 19 or 20 years of age as
14 being 18 years of age).”.

15 (2) OFFSET OF ADDITIONAL EXPENDITURES
16 FOR ENHANCED MATCH FOR PRE-CHIP EXPAN-
17 SION.—Section 1905 of the Social Security Act (42
18 U.S.C. 1396d) is amended—

19 (A) in the fourth sentence of subsection
20 (b), by inserting “(except in the case of expend-
21 itures described in subsection (u)(5))” after “do
22 not exceed”;

23 (B) in subsection (u), by inserting after
24 paragraph (4) (as inserted by subparagraph
25 (C)), the following:



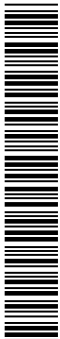
1 “(5) For purposes of the fourth sentence of sub-
2 section (b) and section 2105(a), the following payments
3 under this title do not count against a State’s allotment
4 under section 2104:

5 “(A) REGULAR FMAP FOR EXPENDITURES FOR
6 PREGNANT WOMEN WITH INCOME ABOVE 133 PER-
7 CENT OF POVERTY.—The portion of the payments
8 made for expenditures described in paragraph
9 (4)(A)(ii) that represents the amount that would
10 have been paid if the enhanced FMAP had not been
11 substituted for the Federal medical assistance per-
12 centage.

13 “(B) FAMILYCARE PARENTS.—Payments for
14 expenditures described in paragraph (4)(A)(i).

15 “(C) REGULAR FMAP FOR EXPENDITURES FOR
16 CERTAIN CHILDREN IN FAMILIES WITH INCOME
17 ABOVE MEDICAID MANDATORY LEVEL.—The portion
18 of the payments made for expenditures described in
19 paragraph (4)(B) that represents the amount that
20 would have been paid if the enhanced FMAP had
21 not been substituted for the Federal medical assist-
22 ance percentage.”.

23 “(B) CONFORMING AMENDMENTS.—Sub-
24 paragraph (B) of section 2105(a)(1) of the So-



1 cial Security Act, as amended by subsection
2 (a)(1)(D), is amended to read as follows:

3 “(B) CERTAIN FAMILYCARE PARENTS AND
4 OTHERS.—Expenditures for medical assistance
5 that is attributable to expenditures described in
6 section 1905(u)(4), except as provided in sec-
7 tion 1905(u)(5).”.

8 (3) EFFECTIVE DATE.—The amendments made
9 by this subsection apply as of October 1, 2006, to
10 fiscal years beginning on or after such date and to
11 expenditures under the State plan on and after such
12 date, whether or not regulations implementing such
13 amendments have been issued.

14 (c) GAO STUDY.—

15 (1) STUDY.—The Comptroller General of the
16 United States shall conduct a study regarding fund-
17 ing under title XXI of the Social Security Act that
18 examines—

19 (A) the adequacy of overall funding under
20 such title;

21 (B) the formula for determining allotments
22 and for redistribution of unspent funds under
23 such title; and

24 (C) the effect of waiting lists and caps on
25 enrollment under such title.



1 (2) REPORT.—Not later than July 1, 2007, the
2 Comptroller General shall submit a report on the
3 study conducted under paragraph (1). Such report
4 shall include recommendations regarding a better
5 mechanism for determining State allotments and re-
6 distribution of unspent funds under such title in
7 order to ensure all eligible families in need can ac-
8 cess coverage through such title.

9 (d) CONFORMING AMENDMENTS.—

10 (1) ELIGIBILITY CATEGORIES.—Section
11 1905(a) of the Social Security Act (42 U.S.C.
12 1396d(a)) is amended, in the matter before para-
13 graph (1)—

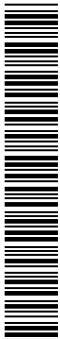
14 (A) by striking “or” at the end of clause
15 (xii);

16 (B) by inserting “or” at the end of clause
17 (xiii); and

18 (C) by inserting after clause (xiii) the fol-
19 lowing:

20 “(xiv) who are parents described (or treated as
21 if described) in section 1902(k)(1),”.

22 (2) INCOME LIMITATIONS.—Section 1903(f)(4)
23 of the Social Security Act (42 U.S.C. 1396b(f)(4))
24 is amended by inserting “1902(a)(10)(A)(ii)(XIX),”
25 after “1902(a)(10)(A)(ii)(XVIII),”.



1 (3) CONFORMING AMENDMENT RELATING TO
2 NO WAITING PERIOD FOR PREGNANT WOMEN.—Sec-
3 tion 2102(b)(1)(B) of the Social Security Act (42
4 U.S.C. 1397bb(b)(1)(B)) is amended—

5 (A) by striking “, and” at the end of
6 clause (i) and inserting a semicolon;

7 (B) by striking the period at the end of
8 clause (ii) and inserting “; and”; and

9 (C) by adding at the end the following:

10 “(iii) may not apply a waiting period
11 (including a waiting period to carry out
12 paragraph (3)(C)) in the case of a targeted
13 low-income parent who is pregnant.”.

14 **SEC. 104. AUTOMATIC ENROLLMENT OF CHILDREN BORN**
15 **TO TITLE XXI PARENTS.**

16 Section 2102(b)(1) of the Social Security Act (42
17 U.S.C. 1397bb(b)(1)) is amended by adding at the end
18 the following:

19 “(C) AUTOMATIC ELIGIBILITY OF CHIL-
20 DREN BORN TO A PARENT BEING PROVIDED
21 FAMILYCARE.—Such eligibility standards shall
22 provide for automatic coverage of a child born
23 to an individual who is provided assistance
24 under this title in the same manner as medical
25 assistance would be provided under section



1 1902(e)(4) to a child described in such sec-
2 tion.”.

3 **SEC. 105. OPTIONAL COVERAGE OF CHILDREN THROUGH**
4 **AGE 20 UNDER THE MEDICAID PROGRAM AND**
5 **TITLE XXI.**

6 (a) MEDICAID.—

7 (1) IN GENERAL.—Section 1902(l)(1)(D) of the
8 Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is
9 amended by inserting “(or, at the election of a
10 State, 20 or 21 years of age)” after “19 years of
11 age”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) Section 1902(e)(3)(A) of the Social Se-
14 curity Act (42 U.S.C. 1396a(e)(3)(A)) is
15 amended by inserting “(or 1 year less than the
16 age the State has elected under subsection
17 (l)(1)(D))” after “18 years of age”.

18 (B) Section 1902(e)(12) of the Social Se-
19 curity Act (42 U.S.C. 1396a(e)(12)) is amend-
20 ed by inserting “or such higher age as the State
21 has elected under subsection (l)(1)(D)” after
22 “19 years of age”.

23 (C) Section 1920A(b)(1) of the Social Se-
24 curity Act (42 U.S.C. 1396r-1a(b)(1)) is
25 amended by inserting “or such higher age as



1 the State has elected under section
2 1902(l)(1)(D))” after “19 years of age”.

3 (D) Section 1928(h)(1) of the Social Secu-
4 rity Act (42 U.S.C. 1396s(h)(1)) is amended by
5 inserting “or 1 year less than the age the State
6 has elected under section 1902(l)(1)(D))” before
7 the period at the end.

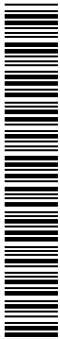
8 (E) Section 1932(a)(2)(A) of the Social
9 Security Act (42 U.S.C. 1396u-2(a)(2)(A)) is
10 amended by inserting “(or such higher age as
11 the State has elected under section
12 1902(l)(1)(D))” after “19 years of age”.

13 (b) TITLE XXI.—Section 2110(c)(1) of the Social
14 Security Act (42 U.S.C. 1397jj(c)(1)) is amended by in-
15 serting “(or such higher age as the State has elected under
16 section 1902(l)(1)(D))”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section take effect on January 1, 2006, and apply to
19 medical assistance and child health assistance provided on
20 or after such date, whether or not regulations imple-
21 menting such amendments have been issued.

22 **SEC. 106. ALLOWING STATES TO SIMPLIFY RULES FOR FAM-**
23 **ILIES.**

24 (a) PRESUMPTIVE ELIGIBILITY.—



1 (1) APPLICATION TO PRESUMPTIVE ELIGIBILITY
2 FOR PREGNANT WOMEN UNDER MEDICAID.—Section
3 1920(b) of the Social Security Act (42 U.S.C.
4 1396r–1(b)) is amended by adding at the end after
5 and below paragraph (2) the following flush sen-
6 tence: “The term ‘qualified provider’ includes a
7 qualified entity as defined in section 1920A(b)(3).”.

8 (2) OPTIONAL APPLICATION OF PRESUMPTIVE
9 ELIGIBILITY PROVISIONS TO PARENTS.—Section
10 1920A of the Social Security Act (42 U.S.C. 1396r–
11 1a) is amended by adding at the end the following:
12 “(e) A State may elect to apply the previous provi-
13 sions of this section to provide for a period of presumptive
14 eligibility for medical assistance for a parent of a child
15 with respect to whom such a period is provided under this
16 section.”.

17 (3) APPLICATION UNDER TITLE XXI.—Section
18 2107(e)(1)(D) of the Social Security Act (42 U.S.C.
19 1397gg(e)(1)) is amended to read as follows:

20 “(D) Sections 1920 and 1920A (relating to
21 presumptive eligibility).”.

22 (b) 12–Months Continuous Eligibility.—

23 (1) MEDICAID.—Section 1902(e)(12) of the So-
24 cial Security Act (42 U.S.C. 1396a(e)(12)) is
25 amended—



1 (A) by striking “At the option of the State,
2 the plan may” and inserting “The plan shall”;

3 (B) by striking “an age specified by the
4 State (not to exceed 19 years of age)” and in-
5 serting “19 years of age (or such higher age as
6 the State has elected under subsection
7 (l)(1)(D)) or, at the option of the State, who is
8 eligible for medical assistance as the parent of
9 such a child”; and

10 (C) in subparagraph (A), by striking “a
11 period (not to exceed 12 months) ” and insert-
12 ing “the 12-month period beginning on the
13 date”.

14 (2) TITLE XXI.—Section 2102(b)(2) of such
15 Act (42 U.S.C. 1397bb(b)(2)) is amended by adding
16 at the end the following: “Such methods shall pro-
17 vide continuous eligibility for children under this
18 title in a manner that is no less generous than the
19 12-months continuous eligibility provided under sec-
20 tion 1902(e)(12) for children described in such sec-
21 tion under title XIX. If a State has elected to apply
22 section 1902(e)(12) to parents, such methods may
23 provide continuous eligibility for parents under this
24 title in a manner that is no less generous than the
25 12-months continuous eligibility provided under such



1 section for parents described in such section under
2 title XIX.”.

3 (3) EFFECTIVE DATE.—The amendments made
4 by this subsection shall take effect on July 1, 2006
5 (or, if later, 60 days after the date of the enactment
6 of this Act), whether or not regulations imple-
7 menting such amendments have been issued.

8 (c) PROVISION OF MEDICAID AND CHIP APPLICA-
9 TIONS AND INFORMATION UNDER THE SCHOOL LUNCH
10 PROGRAM.—Section 9(b)(2)(B) of the Richard B. Russell
11 National School Lunch Act (42 U.S.C. 1758(b)(2)(B)) is
12 amended—

13 (1) by striking “(B) Applications” and inserting
14 “(B)(i) Applications”; and

15 (2) by adding at the end the following:

16 “(ii)(I) Applications for free and reduced price
17 lunches that are distributed pursuant to clause (i) to par-
18 ents or guardians of children in attendance at schools par-
19 ticipating in the school lunch program under this Act shall
20 also contain information on the availability of medical as-
21 sistance under title XIX of the Social Security Act (42
22 U.S.C. 1396 et seq.) and of child health and FamilyCare
23 assistance under title XXI of such Act, including informa-
24 tion on how to obtain an application for assistance under
25 such programs.



1 “(II) Information on the programs referred to in sub-
2 clause (I) shall be provided on a form separate from the
3 application form for free and reduced price lunches under
4 clause (i).”.

5 **SEC. 107. DEMONSTRATION PROGRAMS TO IMPROVE MED-**
6 **ICAID AND CHIP OUTREACH TO HOMELESS**
7 **INDIVIDUALS AND FAMILIES.**

8 (a) **AUTHORITY.**—The Secretary of Health and
9 Human Services may award demonstration grants to not
10 more than 7 States (or other qualified entities) to conduct
11 innovative programs that are designed to improve out-
12 reach to homeless individuals and families under the pro-
13 grams described in subsection (b) with respect to enroll-
14 ment of such individuals and families under such pro-
15 grams and the provision of services (and coordinating the
16 provision of such services) under such programs.

17 (b) **PROGRAMS FOR HOMELESS DESCRIBED.**—The
18 programs described in this subsection are as follows:

19 (1) **MEDICAID.**—The program under title XIX
20 of the Social Security Act (42 U.S.C. 1396 et seq.).

21 (2) **CHIP.**—The program under title XXI of
22 the Social Security Act (42 U.S.C. 1397aa et seq.).

23 (3) **TANF.**—The program under part of A of
24 title IV of the Social Security Act (42 U.S.C. 601
25 et seq.).



1 (4) SAMHSA BLOCK GRANTS.—The program
2 of grants under part B of title XIX of the Public
3 Health Service Act (42 U.S.C. 300x–1 et seq.).

4 (5) FOOD STAMP PROGRAM.—The program
5 under the Food Stamp Act of 1977 (7 U.S.C. 2011
6 et seq.).

7 (6) WORKFORCE INVESTMENT ACT.—The pro-
8 gram under the Workforce Investment Act of 1999
9 (29 U.S.C. 2801 et seq.).

10 (7) WELFARE-TO-WORK.—The welfare-to-work
11 program under section 403(a)(5) of the Social Secu-
12 rity Act (42 U.S.C. 603(a)(5)).

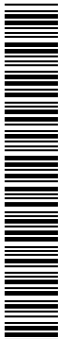
13 (8) OTHER PROGRAMS.—Other public and pri-
14 vate benefit programs that serve low-income individ-
15 uals.

16 (c) APPROPRIATIONS.—For the purposes of carrying
17 out this section, there is appropriated for fiscal year 2006,
18 out of any funds in the Treasury not otherwise appro-
19 priated, \$10,000,000, to remain available until expended.

20 **SEC. 108. ADDITIONAL CHIP REVISIONS.**

21 (a) LIMITING COST-SHARING TO 2.5 PERCENT FOR
22 FAMILIES WITH INCOME BELOW 150 PERCENT OF POV-
23 ERTY.—Section 2103(e)(3)(A) of the Social Security Act
24 (42 U.S.C. 1397cc(e)(3)(A)) is amended—

25 (1) by striking “and” at the end of clause (i);



1 (2) by striking the period at the end of clause
2 (ii) and inserting “; and”; and

3 (3) by adding at the end the following new
4 clause:

5 “(iii) total annual aggregate cost-
6 sharing described in clauses (i) and (ii)
7 with respect to all such targeted low-in-
8 come children in a family under this title
9 that exceeds 2.5 percent of such family’s
10 income for the year involved.”.

11 (b) EMPLOYER COVERAGE WAIVER CHANGES.—Sec-
12 tion 2105(c)(3) of such Act (42 U.S.C. 1397ee(c)(3)) is
13 amended—

14 (1) by redesignating subparagraphs (A) and
15 (B) as clauses (i) and (ii) and indenting appro-
16 priately;

17 (2) by designating the matter beginning with
18 “Payment may be made” as a subparagraph (A)
19 with the heading “**IN GENERAL**” and indenting ap-
20 propriately; and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(B) APPLICATION OF REQUIREMENTS.—
24 In carrying out subparagraph (A)—



1 “(i) in determining cost-effectiveness,
2 the Secretary shall measure against family
3 coverage costs to the extent that a State
4 has expanded coverage to parents pursuant
5 to section 2111;

6 “(ii) subject to clause (iii), the State
7 shall provide satisfactory assurances that
8 the minimum benefits and cost-sharing
9 protections established under this title are
10 provided, either through the coverage
11 under subparagraph (A) or as a supple-
12 ment to such coverage; and

13 “(iii) coverage under such subpara-
14 graph shall not be considered to violate
15 clause (ii) because it does not comply with
16 requirements relating to reviews of health
17 service decisions if the enrollee involved is
18 provided the option of being provided bene-
19 fits directly under this title.”.

20 (c) EFFECTIVE DATE.—The amendments made by
21 this section apply as of January 1, 2006, whether or not
22 regulations implementing such amendments have been
23 issued.



1 **SEC. 109. COORDINATION OF TITLE XXI WITH THE MATER-**
2 **NAL AND CHILD HEALTH PROGRAM.**

3 (a) IN GENERAL.—Section 2102(b)(3) of the Social
4 Security Act (42 U.S.C. 1397bb(b)(3)) is amended—

5 (1) in subparagraph (D), by striking “and” at
6 the end;

7 (2) in subparagraph (E), by striking the period
8 and inserting “; and”; and

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(F) that operations and activities under
12 this title are developed and implemented in con-
13 sultation and coordination with the program op-
14 erated by the State under title V in areas in-
15 cluding outreach and enrollment, benefits and
16 services, service delivery standards, public
17 health and social service agency relationships,
18 and quality assurance and data reporting.”.

19 (b) CONFORMING MEDICAID AMENDMENT.—Section
20 1902(a)(11) of such Act (42 U.S.C. 1396a(a)(11)) is
21 amended—

22 (1) by striking “and” before “(C)”; and

23 (2) by inserting before the semicolon at the end
24 the following: “, and (D) provide that operations and
25 activities under this title are developed and imple-
26 mented in consultation and coordination with the



1 program operated by the State under title V in areas
2 including outreach and enrollment, benefits and
3 services, service delivery standards, public health
4 and social service agency relationships, and quality
5 assurance and data reporting”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section take effect on January 1, 2006.

8 **Subtitle B—State Option to Pro-**
9 **vide Coverage for All Residents**
10 **With Income at or Below the**
11 **Poverty Line**

12 **SEC. 121. STATE OPTION TO PROVIDE COVERAGE FOR ALL**
13 **RESIDENTS WITH INCOME AT OR BELOW THE**
14 **POVERTY LINE.**

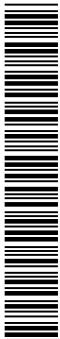
15 (a) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the
16 Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is
17 amended—

18 (1) by striking “or” at the end of subclause
19 (XVII);

20 (2) by adding “or” at the end of subclause
21 (XVIII); and

22 (3) by adding at the end the following new sub-
23 clause:

24 “(XIX) any individual whose
25 family income does not exceed 100



1 percent of the income official poverty
2 line (as defined by the Office of Man-
3 agement and Budget, and revised an-
4 nually in accordance with section
5 673(2) of the Omnibus Budget Rec-
6 onciliation Act of 1981) applicable to
7 a family of the size involved and who
8 is not otherwise eligible for medical
9 assistance under this title;”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) Section 1905(a) of such Act (42 U.S.C.
12 1396d(a)) is amended, in the matter before para-
13 graph (1)—

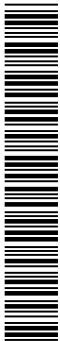
14 (A) by striking “or” at the end of clause
15 (xii);

16 (B) by adding “or” at the end of clause
17 (xiii); and

18 (C) by inserting after clause (xiii) the fol-
19 lowing new clause:

20 “(xii) individuals described in section
21 1902(a)(10)(A)(ii)(XIX),”.

22 (2) Section 1903(f)(4) of such Act (42 U.S.C.
23 1396b(f)(4)) is amended by inserting
24 “1902(a)(10)(A)(ii)(XIX),” after
25 “1902(a)(10)(A)(ii)(XVIII),”.



1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect on October 1, 2006.

3 **Subtitle C—Optional Coverage of**
4 **Legal Immigrants Under the**
5 **Medicaid Program and Title**
6 **XXI, and to Extend Eligibility to**
7 **Certain Legal Residents**

8 **SEC. 131. EQUAL ACCESS TO HEALTH COVERAGE FOR**
9 **LEGAL IMMIGRANTS.**

10 (a) IN GENERAL.—Section 401(b)(1) of the Personal
11 Responsibility and Work Opportunity Reconciliation Act
12 of 1996 (8 U.S.C. 1611(b)(1)) is amended—

13 (1) by striking subparagraph (A) and inserting
14 the following:

15 “(A) Medical assistance under title XIX of
16 the Social Security Act.”; and

17 (2) by adding at the end the following:

18 “(F) Child health assistance under title
19 XXI of the Social Security Act.”.

20 (b) CONFORMING AMENDMENTS.—

21 (1) Section 402(b) of the Personal Responsi-
22 bility and Work Opportunity Reconciliation Act of
23 1996 (8 U.S.C. 1612(b)) is amended—

24 (A) in paragraph (2)—

25 (i) in subparagraph (A)—



1 (I) by striking clause (i);
2 (II) by redesignating clause (ii)
3 as subparagraph (A) and realigning
4 the margins accordingly; and
5 (III) by redesignating subclauses
6 (I) through (V) of subparagraph (A),
7 as so redesignated, as clauses (i)
8 through (v), respectively and realign-
9 ing the margins accordingly; and
10 (ii) by striking subparagraphs (E) and
11 (F); and

12 (B) in paragraph (3), by striking subpara-
13 graph (C).

14 (2) Section 403 of the Personal Responsibility
15 and Work Opportunity Reconciliation Act of 1996 (8
16 U.S.C. 1613)) is amended—

17 (A) in subsection (c), by adding at the end
18 the following:

19 “(M) Child health assistance provided
20 under title XXI of the Social Security Act.”;
21 and

22 (B) in subsection (d)(1), by striking “pro-
23 grams specified in subsections (a)(3) and
24 (b)(3)(C)” and inserting “program specified in
25 subsection (a)(3)”.



1 (3) Section 421 of the Personal Responsibility
2 and Work Opportunity Reconciliation Act of 1996 (8
3 U.S.C. 1631)) is amended by adding at the end the
4 following:

5 “(g) EXCEPTIONS.—This section shall not apply to—

6 “(1) medical assistance provided under a State
7 plan approved under title XIX of the Social Security
8 Act; and

9 “(2) child health assistance provided under title
10 XXI of the Social Security Act.”.

11 (4) Section 423(d) of the Personal Responsi-
12 bility and Work Opportunity Reconciliation Act of
13 1996 is amended by adding at the end the following:

14 “(12) Child health assistance provided under
15 title XXI of the Social Security Act.”.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the amendments made by this section
19 take effect on the date of enactment of this Act and
20 apply to medical assistance provided under title XIX
21 of the Social Security Act and child health assist-
22 ance provided under title XXI of the Social Security
23 Act on or after that date.

24 (2) REQUIREMENTS FOR SPONSOR’S AFFIDAVIT
25 OF SUPPORT.—Section 423(d) of the Personal Re-



1 sponsibility and Work Opportunity Reconciliation
2 Act of 1996 shall be applied as if the amendments
3 made by this Act were enacted on December 1,
4 2002.

5 SEC. 132. EXCEPTION FOR CITIZENS OF FREELY ASSOCI-
6 ATED STATES.

7 (a) .—

(b) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

“(M) EXCEPTION FOR CITIZENS OF FREE-
LY ASSOCIATED STATES.—With respect to eligi-
bility for benefits for the specified Federal pro-
grams described in paragraph (3), paragraph
(1) shall not apply to any individual who law-
fully resides in the United States (including ter-
ritories and possessions of the United States) in
accordance with—

20 “(i) section 141 of the Compact of
21 Free Association between the Government
22 of the United States and the Government
23 of the Federated States of Micronesia, ap-
24 proved by Congress in the Compact of



1 Free Association Amendments Act of
2 2003;

3 “(ii) section 141 of the Compact of
4 Free Association between the Government
5 of the United States and the Government
6 of the Republic of the Marshall Islands,
7 approved by Congress in the Compact of
8 Free Association Amendments Act of
9 2003; or

10 “(iii) section 141 of the Compact of
11 Free Association between the Government
12 of the United States and the Government
13 of Palau, approved by Congress in Public
14 Law 99–658 (100 Stat. 3672).”.

15 (c) MEDICAID EXCEPTION.—Section 402(b)(2) of the
16 Personal Responsibility and Work Opportunity Reconcili-
17 ation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by
18 adding at the end the following:

19 “(G) MEDICAID EXCEPTIONS FOR CITI-
20 ZENS OF FREELY ASSOCIATED STATES.—With
21 respect to eligibility for benefits for the pro-
22 grams defined in subparagraphs (A) and (C) of
23 paragraph (3) (relating to medicaid), paragraph
24 (1) shall not apply to any individual who law-
25 fully resides in the United States (including ter-



1 ritories and possessions of the United States) in
2 accordance with a Compact of Free Association
3 referred to in subsection (a)(2)(M).”.

4 (d) QUALIFIED ALIEN.—Section 431(b) of the Per-
5 sonal Responsibility and Work Opportunity Reconciliation
6 Act of 1996 (8 U.S.C. 1641(b)) is amended—

7 (1) in paragraph (6), by striking “or” at the
8 end;

9 (2) in paragraph (7), by striking the period at
10 the end and inserting “; or”; and

11 (3) by adding at the end the following:

12 “(8) an individual who lawfully resides in the
13 United States (including territories and possessions
14 of the United States) in accordance with a Compact
15 of Free Association referred to in section
16 402(a)(2)(M).”.

17 (e) FINANCIAL TREATMENT UNDER MEDICAID.—

18 (1) REMOVAL FROM MEDICAID CAP.—Section
19 1108 of the Social Security Act (42 U.S.C. 1308) is
20 amended

21 (A) in subsection (f), by striking “sub-
22 section (g)” and inserting “subsections (g) and
23 (h)”; and

24 (B) by adding at the end the following new
25 subsection:



1 “(h) The limitations of subsections (f) and (g) shall
2 not apply with respect to medical assistance provided to
3 an individual described in section 431(b)(8) of the Per-
4 sonal Responsibility and Work Opportunity Reconciliation
5 Act of 1996.”.

6 (2) INCREASED FMAP.—The third sentence of
7 section 1905(b) of the Social Security Act (42
8 U.S.C. 1396d(b)) is amended by inserting before the
9 period at the end the following: “and for services
10 furnished to individuals described in section
11 431(b)(8) of the Personal Responsibility and Work
12 Opportunity Reconciliation Act of 1996”.

13 **Subtitle D—Indian Healthcare** 14 **Funding**

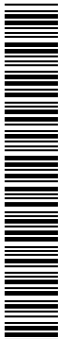
15 **CHAPTER 1—GUARANTEED FUNDING**

16 **SEC. 141. GUARANTEED ADEQUATE FUNDING FOR INDIAN** 17 **HEALTHCARE.**

18 Section 825 of the Indian Health Care Improvement
19 Act (25 U.S.C. 1680o) is amended to read as follows:

20 **“SEC. 825. FUNDING.**

21 “(a) IN GENERAL.—Notwithstanding any other pro-
22 vision of law, not later than 30 days after the date of en-
23 actment of this section, on October 1, 2007, and on each
24 October 1 thereafter, out of any funds in the Treasury
25 not otherwise appropriated, the Secretary of the Treasury



1 shall transfer to the Secretary to carry out this title the
2 amount determined under subsection (d).

3 “(b) USE AND AVAILABILITY.—

4 “(1) IN GENERAL.—An amount transferred
5 under subsection (a)—

6 “(A) shall remain available until expended;

7 and

8 “(B) shall be used to carry out any pro-
9 grams, functions, and activities relating to clin-
10 ical services (as defined in paragraph (2)) of
11 the Service and Service units.

12 “(2) CLINICAL SERVICES DEFINED.—For pur-
13 poses of paragraph (1)(B), the term ‘clinical serv-
14 ices’ includes all programs of the Indian Health
15 Service which are funded directly or under the au-
16 thority of the Indian Self-Determination and Edu-
17 cation Assistance Act, for the purposes of—

18 “(A) clinical care, including inpatient care,
19 outpatient care (including audiology, clinical eye
20 and vision care), primary care, secondary and
21 tertiary care, and long term care;

22 “(B) preventive health, including mam-
23 mography and other cancer screening;

24 “(C) dental care;



1 “(D) mental and behavioral health, includ-
2 ing community mental and behavioral health
3 services, inpatient mental and behavioral health
4 services, dormitory mental and behavioral
5 health services, therapeutic and residential
6 treatment centers;

7 “(E) emergency medical services;

8 “(F) treatment and control of, and reha-
9 bitative care related to, alcoholism and drug
10 abuse (including fetal alcohol syndrome) among
11 Indians;

12 “(G) accident prevention programs;

13 “(H) home healthcare;

14 “(I) community health representatives;

15 “(J) maintenance and repair; and

16 “(K) traditional healthcare practices and
17 training of traditional healthcare practitioners.

18 “(c) RECEIPT AND ACCEPTANCE.—The Secretary
19 shall be entitled to receive, shall accept, and shall use to
20 carry out this title the funds transferred under subsection
21 (a), without further appropriation.

22 “(d) AMOUNT.—The amount referred to in sub-
23 section (a) is—

24 “(1) for fiscal year 2006, the amount equal to
25 390 percent of the amount obligated by the Service



1 during fiscal year 2002 for the purposes described in
2 subsection (b)(2); and

3 “(2) for fiscal year 2007 and each fiscal year
4 thereafter, the amount equal to the product obtained
5 by multiplying—

6 “(A) the number of Indians served by the
7 Service as of September 30 of the preceding the
8 fiscal year; and

9 “(B) the per capita baseline amount, as
10 determined under subsection (e).

11 “(e) PER CAPITA BASELINE AMOUNT.—

12 “(1) IN GENERAL.—For the purpose of sub-
13 section (d)(2)(B), the per capita baseline amount
14 shall be equal to the sum of—

15 “(A) the quotient obtained by dividing—

16 “(i) the amount specified in sub-
17 section (d)(1); by

18 “(ii) the number of Indians served by
19 the Service as of September 30, 2002; and

20 “(B) any applicable increase under para-
21 graph (2).

22 “(2) INCREASE.—For each fiscal year, the Sec-
23 retary shall provide a percentage increase (rounded
24 to the nearest dollar) in the per capita baseline
25 amount equal to the percentage by which—



1 “(A) the Consumer Price Index for all
2 Urban Consumers published by the Department
3 of Labor (relating to the United States city av-
4 erage for medical care and not seasonally ad-
5 justed) for the 1-year period ending on the
6 June 30 of the fiscal year preceding the fiscal
7 year for which the increase is made; exceeds

8 “(B) that Consumer Price Index for the 1-
9 year period preceding the 1-year period de-
10 scribed in subparagraph (A).”.

11 **CHAPTER 2—INDIAN HEALTHCARE**
12 **PROGRAMS**

13 **SEC. 145. PROGRAMS OPERATED BY INDIAN TRIBES AND**
14 **TRIBAL ORGANIZATIONS.**

15 The Service shall provide funds for healthcare pro-
16 grams and facilities operated by Indian tribes and tribal
17 organizations under funding agreements with the Service
18 entered into under the Indian Self-Determination and
19 Education Assistance Act on the same basis as such funds
20 are provided to programs and facilities operated directly
21 by the Service.

22 **SEC. 146. LICENSING.**

23 Healthcare professionals employed by Indian tribes
24 and tribal organizations to carry out agreements under the
25 Indian Self-Determination and Education Assistance Act,



1 shall, if licensed in any State, be exempt from the licensing
2 requirements of the State in which the agreement is per-
3 formed.

4 **SEC. 147. AUTHORIZATION FOR EMERGENCY CONTRACT**
5 **HEALTH SERVICES.**

6 With respect to an elderly Indian or an Indian with
7 a disability receiving emergency medical care or services
8 from a non-Service provider or in a non-Service facility
9 under the authority of the Indian Health Care Improve-
10 ment Act, the time limitation (as a condition of payment)
11 for notifying the Service of such treatment or admission
12 shall be 30 days.

13 **SEC. 148. PROMPT ACTION ON PAYMENT OF CLAIMS.**

14 (a) REQUIREMENT.—The Service shall respond to a
15 notification of a claim by a provider of a contract care
16 service with either an individual purchase order or a denial
17 of the claim within 5 working days after the receipt of
18 such notification.

19 (b) FAILURE TO RESPOND.—If the Service fails to
20 respond to a notification of a claim in accordance with
21 subsection (a), the Service shall accept as valid the claim
22 submitted by the provider of a contract care service.

23 (c) PAYMENT.—The Service shall pay a valid contract
24 care service claim within 30 days after the completion of
25 the claim.



1 **SEC. 149. LIABILITY FOR PAYMENT.**

2 (a) NO LIABILITY.—A patient who receives contract
3 healthcare services that are authorized by the Service shall
4 not be liable for the payment of any charges or costs asso-
5 ciated with the provision of such services.

6 (b) NOTIFICATION.—The Secretary shall notify a
7 contract care provider and any patient who receives con-
8 tract healthcare services authorized by the Service that
9 such patient is not liable for the payment of any charges
10 or costs associated with the provision of such services.

11 (c) LIMITATION.—Following receipt of the notice pro-
12 vided under subsection (b), or, if a claim has been deemed
13 accepted under section 154(b), the provider shall have no
14 further recourse against the patient who received the serv-
15 ices involved.

16 **SEC. 150. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

17 (a) INELIGIBLE PERSONS.—

18 (1) IN GENERAL.—Any individual who—

19 (A) has not attained 19 years of age;

20 (B) is the natural or adopted child, step-
21 child, foster-child, legal ward, or orphan of an
22 eligible Indian; and

23 (C) is not otherwise eligible for the health
24 services provided by the Service, shall be eligible
25 for all health services provided by the Service
26 on the same basis and subject to the same rules



1 that apply to eligible Indians until such indi-
2 vidual attains 19 years of age. The existing and
3 potential health needs of all such individuals
4 shall be taken into consideration by the Service
5 in determining the need for, or the allocation
6 of, the health resources of the Service. If such
7 an individual has been determined to be legally
8 incompetent prior to attaining 19 years of age,
9 such individual shall remain eligible for such
10 services until one year after the date such dis-
11 ability has been removed.

12 (2) SPOUSES.—Any spouse of an eligible Indian
13 who is not an Indian, or who is of Indian descent
14 but not otherwise eligible for the health services pro-
15 vided by the Service, shall be eligible for such health
16 services if all of such spouses or spouses who are
17 married to members of the Indian tribe being served
18 are made eligible, as a class, by an appropriate reso-
19 lution of the governing body of the Indian tribe or
20 tribal organization providing such services. The
21 health needs of persons made eligible under this
22 paragraph shall not be taken into consideration by
23 the Service in determining the need for, or allocation
24 of, its health resources.

25 (b) PROGRAMS AND SERVICES.—



1 (1) PROGRAMS.—

2 (A) IN GENERAL.—The Secretary may
3 provide health services under this subsection
4 through health programs operated directly by
5 the Service to individuals who reside within the
6 service area of a service unit and who are not
7 eligible for such health services under any other
8 subsection of this section or under any other
9 provision of law if—

10 (i) the Indian tribe (or, in the case of
11 a multi-tribal service area, all the Indian
12 tribes) served by such service unit requests
13 such provision of health services to such
14 individuals; and

15 (ii) the Secretary and the Indian tribe
16 or tribes have jointly determined that—

17 (I) the provision of such health
18 services will not result in a denial or
19 diminution of health services to eligi-
20 ble Indians; and

21 (II) there is no reasonable alter-
22 native health program or services,
23 within or without the service area of
24 such service unit, available to meet
25 the health needs of such individuals.



1 (B) FUNDING AGREEMENTS.—In the case
2 of health programs operated under a funding
3 agreement entered into under the Indian Self-
4 Determination and Educational Assistance Act,
5 the governing body of the Indian tribe or tribal
6 organization providing health services under
7 such funding agreement is authorized to deter-
8 mine whether health services should be provided
9 under such funding agreement to individuals
10 who are not eligible for such health services
11 under any other subsection of this section or
12 under any other provision of law. In making
13 such determinations, the governing body of the
14 Indian tribe or tribal organization shall take
15 into account the considerations described in
16 subparagraph (A)(ii).

17 (2) LIABILITY FOR PAYMENT.—

18 (A) IN GENERAL.—Persons receiving
19 health services provided by the Service by rea-
20 son of this subsection shall be liable for pay-
21 ment of such health services under a schedule
22 of charges prescribed by the Secretary which, in
23 the judgment of the Secretary, results in reim-
24 bursement in an amount not less than the ac-
25 tual cost of providing the health services. Not-



1 withstanding section 1880 of the Social Secu-
2 rity Act or any other provision of law, amounts
3 collected under this subsection, including medi-
4 care or medicaid reimbursements under titles
5 XVIII and XIX of the Social Security Act, shall
6 be credited to the account of the program pro-
7 viding the service and shall be used solely for
8 the provision of health services within that pro-
9 gram. Amounts collected under this subsection
10 shall be available for expenditure within such
11 program for not to exceed 1 fiscal year after
12 the fiscal year in which collected.

13 (B) SERVICES FOR INDIGENT PERSONS.—
14 Health services may be provided by the Sec-
15 retary through the Service under this sub-
16 section to an indigent person who would not be
17 eligible for such health services but for the pro-
18 visions of paragraph (1) only if an agreement
19 has been entered into with a State or local gov-
20 ernment under which the State or local govern-
21 ment agrees to reimburse the Service for the
22 expenses incurred by the Service in providing
23 such health services to such indigent person.

24 (3) SERVICE AREAS.—



1 (A) SERVICE TO ONLY ONE TRIBE.—In the
2 case of a service area which serves only one In-
3 dian tribe, the authority of the Secretary to
4 provide health services under paragraph (1)(A)
5 shall terminate at the end of the fiscal year suc-
6 ceeding the fiscal year in which the governing
7 body of the Indian tribe revokes its concurrence
8 to the provision of such health services.

9 (B) MULTI-TRIBAL AREAS.—In the case of
10 a multi-tribal service area, the authority of the
11 Secretary to provide health services under para-
12 graph (1)(A) shall terminate at the end of the
13 fiscal year succeeding the fiscal year in which at
14 least 51 percent of the number of Indian tribes
15 in the service area revoke their concurrence to
16 the provision of such health services.

17 (c) PURPOSE FOR PROVIDING SERVICES.—The Serv-
18 ice may provide health services under this subsection to
19 individuals who are not eligible for health services provided
20 by the Service under any other subsection of this section
21 or under any other provision of law in order to—

- 22 (1) achieve stability in a medical emergency;
23 (2) prevent the spread of a communicable dis-
24 ease or otherwise deal with a public health hazard;



1 (3) provide care to non-Indian women pregnant
2 with an eligible Indian's child for the duration of the
3 pregnancy through post partum; or

4 (4) provide care to immediate family members
5 of an eligible person if such care is directly related
6 to the treatment of the eligible person.

7 (d) HOSPITAL PRIVILEGES.—Hospital privileges in
8 health facilities operated and maintained by the Service
9 or operated under a contract entered into under the Indian
10 Self-Determination Education Assistance Act may be ex-
11 tended to non-Service healthcare practitioners who provide
12 services to persons described in subsection (a) or (b). Such
13 non-Service healthcare practitioners may be regarded as
14 employees of the Federal Government for purposes of sec-
15 tion 1346(b) and chapter 171 of title 28, United States
16 Code (relating to Federal tort claims) only with respect
17 to acts or omissions which occur in the course of providing
18 services to eligible persons as a part of the conditions
19 under which such hospital privileges are extended.

20 (e) DEFINITION.—In this section, the term “eligible
21 Indian” means any Indian who is eligible for health serv-
22 ices provided by the Service without regard to the provi-
23 sions of this section.



1 **SEC. 151. DEFINITIONS.**

2 For purposes of this chapter, the definitions con-
3 tained in section 4 of the Indian Health Care Improve-
4 ment Act shall apply.

5 **SEC. 152. AUTHORIZATION OF APPROPRIATIONS.**

6 There are authorized to be appropriated such sums
7 as may be necessary for each fiscal year through fiscal
8 year 2015 to carry out this chapter.

9 **Subtitle E—Territories**

10 **SEC. 161. FUNDING FOR TERRITORIES.**

11 (a) TEMPORARY ELIMINATION OF SPENDING CAP.—
12 Section 1108 of the Social Security Act (42 U.S.C. 1308)
13 is amended—

14 (1) in subsection (f), by striking “subsection
15 (g)” and inserting “subsections (g) and (h)”; and

16 (2) by adding at the end the following:

17 “(h) TEMPORARY ELIMINATION OF CAPS.—With re-
18 spect to each of fiscal years 2006 through 2009, the Sec-
19 retary shall make payments under title XIX to Puerto
20 Rico, the Virgin Islands, Guam, the Northern Mariana Is-
21 lands, and American Samoa without regard to the limita-
22 tions on the amount of such payments imposed under sub-
23 sections (f) and (g).”.

24 (b) TEMPORARY INCREASE IN FMAP.—The first
25 sentence of section 1905(b) of the Social Security Act (42
26 U.S.C. 1396d(b)) is amended by inserting “(except that,



1 only with respect to fiscal years 2006 through 2009 and
2 only for purposes of expenditures under this title, such
3 percentage shall be 77 percent)” after “50 per centum”.

4 **Subtitle F—Migrant Workers and**
5 **Farmworkers Health**

6 **SEC. 171. DEMONSTRATION PROJECT REGARDING CON-**
7 **TINUITY OF COVERAGE OF MIGRANT WORK-**
8 **ERS AND FARMWORKERS UNDER MEDICAID**
9 **AND CHIP.**

10 (a) AUTHORITY TO CONDUCT DEMONSTRATION
11 PROJECT.—

12 (1) IN GENERAL.—The Secretary of Health and
13 Human Services shall conduct a demonstration
14 project for the purpose of evaluating methods for
15 strengthening the health coverage of, and continuity
16 of coverage of, migrant workers and farmworkers
17 under the medicaid and State children’s health in-
18 surance programs (42 U.S.C. 1396 et seq., 1397aa
19 et seq.).

20 (2) WAIVER AUTHORITY.—The Secretary of
21 Health and Human Services shall waive compliance
22 with the requirements of titles XI, XIX, and XXI of
23 the Social Security Act (42 U.S.C. 1301 et seq,
24 1396 et seq., 1397aa et seq.) to such extent and for
25 such period as the Secretary determines is necessary



1 to conduct the demonstration project under this sec-
2 tion.

3 (b) REQUIREMENTS.—The demonstration project
4 conducted under this section shall provide for—

5 (1) uniform eligibility criteria under the med-
6 icaid and State children's health insurance programs
7 with respect to migrant workers and farmworkers;
8 and

9 (2) the portability of coverage of such workers
10 under those programs between participating States.

11 (c) REPORT.—Not later than March 31, 2007, the
12 Secretary of Health and Human Services shall submit a
13 report to Congress on the demonstration project con-
14 ducted under this section that contains such recommenda-
15 tions for legislative action as the Secretary determines is
16 appropriate.

17 **Subtitle G—Expanded Access to**
18 **Health Care**

19 **SEC. 181. NATIONAL COMMISSION FOR EXPANDED ACCESS**
20 **TO HEALTH CARE.**

21 (a) ESTABLISHMENT.—There is established a com-
22 mission to be known as the National Commission for Ex-
23 panded Access to Health Care (referred to in this section
24 as the “Commission”).

25 (b) APPOINTMENT OF MEMBERS.—



1 (1) IN GENERAL.—Not later than 45 days after
2 the date of enactment of this Act—

3 (A) the majority and minority leaders of
4 the Senate and the Speaker and minority leader
5 of the House of Representatives shall each ap-
6 point 7 members of the Commission; and

7 (B) the Secretary of Health and Human
8 Services (in this section referred to as the “Sec-
9 retary”) shall appoint 1 member of the Com-
10 mission.

11 (2) CRITERIA.—Members of the Commission
12 shall include representatives of the following:

13 (A) Consumers of health insurance.

14 (B) Health care professionals.

15 (C) State and territorial officials.

16 (D) Health economists.

17 (E) Health care providers.

18 (F) Experts on health insurance.

19 (G) Experts on expanding health care to
20 individuals who are uninsured.

21 (H) Experts on the elimination of racial
22 and ethnic health disparities.

23 (I) Experts on health care in the United
24 States territories.



1 (3) CHAIRPERSON.—At the first meeting of the
2 Commission, the Commission shall select a Chair-
3 person from among its members.

4 (c) MEETINGS.—

5 (1) IN GENERAL.—After the initial meeting of
6 the Commission, which shall be called by the Sec-
7 retary, the Commission shall meet at the call of the
8 Chairperson.

9 (2) QUORUM.—A majority of the members of
10 the Commission shall constitute a quorum, but a
11 lesser number of members may hold hearings.

12 (3) SUPERMAJORITY VOTING REQUIREMENT.—
13 To approve a report required under paragraph (1),
14 (2), or (3) of subsection (e), at least 60 percent of
15 the membership of the Commission must vote in
16 favor of such a report.

17 (d) DUTIES.—The Commission shall—

18 (1) assess the effectiveness of programs de-
19 signed to expand health care coverage or make
20 health care coverage affordable to uninsured individ-
21 uals by identifying the accomplishments and needed
22 improvements of each program;

23 (2) make recommendations regarding the bene-
24 fits and cost-sharing that should be included in



1 health care coverage for various groups, taking into
2 account—

3 (A) the special health care needs of chil-
4 dren and individuals with disabilities;

5 (B) the different ability of various popu-
6 lations to pay out-of-pocket costs for services;

7 (C) incentives for efficiency and cost-con-
8 tainment;

9 (D) racial and ethnic disparities in health
10 status and health care;

11 (E) incremental changes to the United
12 States health care delivery system and changes
13 to achieve fundamental restructuring of the sys-
14 tem;

15 (F) populations who are traditionally more
16 difficult to cover, including immigrants and
17 homeless persons;

18 (G) preventive care, diagnostic services,
19 disease management services, and other factors;

20 (H) quality improvement initiatives among
21 health institutions serving disadvantaged pa-
22 tient populations; and

23 (I) the feasibility of and barriers to the de-
24 velopment of a comprehensive system of health
25 care;



1 (3) recommend mechanisms to expand health
2 care coverage to uninsured individuals;

3 (4) recommend automatic enrollment and reten-
4 tion procedures and other measures to increase
5 health care coverage among those eligible for assist-
6 ance; and

7 (5) analyze the size, effectiveness, and efficiency
8 of current tax and other subsidies for health care
9 coverage and recommend improvements.

10 (e) REPORTS.—

11 (1) ANNUAL REPORTS.—The Commission shall
12 submit annual reports to the President and the ap-
13 propriate committees of Congress addressing the
14 matters identified in subsection (d).

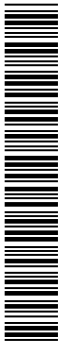
15 (2) BIENNIAL REPORT.—The Commission shall
16 submit biennial reports to the President and the ap-
17 propriate committees of Congress containing—

18 (A) recommendations concerning essential
19 benefits and maximum out-of-pocket cost-shar-
20 ing for—

21 (i) the general population; and

22 (ii) individuals with limited ability to
23 pay; and

24 (B) proposed legislative language to imple-
25 ment such recommendations.



1 (3) COMMISSION REPORT.—Not later than Jan-
2 uary 15, 2007, the Commission shall submit a re-
3 port to the President and the appropriate commit-
4 tees of Congress, which shall include—

5 (A) recommendations on policies to provide
6 health care coverage to uninsured individuals;

7 (B) recommendations on changes to poli-
8 cies enacted under this Act; and

9 (C) proposed legislative language to imple-
10 ment such recommendations.

11 (f) ADMINISTRATION.—

12 (1) POWERS.—

13 (A) HEARINGS.—The Commission may
14 hold such hearings, sit and act at such times
15 and places, take such testimony, and receive
16 such evidence as the Commission considers ad-
17 visable to carry out this section.

18 (B) INFORMATION FROM FEDERAL AGEN-
19 CIES.—The Commission may secure directly
20 from any Federal department or agency such
21 information as the Commission considers nec-
22 essary to carry out this section. Upon request
23 of the Chairperson of the Commission, the head
24 of such department or agency shall furnish such
25 information to the Commission.



1 (C) POSTAL SERVICES.—The Commission
2 may use the United States mails in the same
3 manner and under the same conditions as other
4 departments and agencies of the Federal Gov-
5 ernment.

6 (D) GIFTS.—The Commission may accept,
7 use, and dispose of donations of services or
8 property.

9 (2) COMPENSATION.—

10 (A) IN GENERAL.—Each member of the
11 Commission who is not an officer or employee
12 of the Federal Government shall be com-
13 pensated at a rate equal to the daily equivalent
14 of the annual rate of basic pay prescribed for
15 level IV of the Executive Schedule under section
16 5315 of title 5, United States Code, for each
17 day (including travel time) during which such
18 member is engaged in the performance of duties
19 of the Commission. All members of the Com-
20 mission who are officers or employees of the
21 United States shall serve without compensation
22 in addition to that received for their services as
23 officers or employees of the United States.

24 (B) TRAVEL EXPENSES.—The members of
25 the Commission shall be allowed travel ex-



1 penses, as authorized by the Chairperson of the
2 Commission, including per diem in lieu of sub-
3 sistence, at rates authorized for employees of
4 agencies under subchapter I of chapter 57 of
5 title 5, United States Code, while away from
6 their homes or regular places of business in the
7 performance of services for the Commission.

8 (3) STAFF.—

9 (A) IN GENERAL.—The Chairperson of the
10 Commission may appoint an executive director
11 such other staff as may be necessary to enable
12 the Commission to perform its duties. The em-
13 ployment of an executive director shall be sub-
14 ject to confirmation by the Commission.

15 (B) STAFF COMPENSATION.—The Chair-
16 person of the Commission may fix the com-
17 pensation of personnel without regard to chap-
18 ter 51 and subchapter III of chapter 53 of title
19 5, United States Code, relating to classification
20 of positions and General Schedule pay rates, ex-
21 cept that the rate of pay for personnel may not
22 exceed the rate payable for level V of the Exec-
23 utive Schedule under section 5316 of such title.

24 (C) DETAIL OF GOVERNMENT EMPLOY-
25 EES.—Any Federal Government employee may

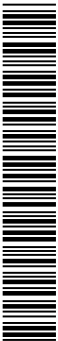


1 be detailed to the Commission without reim-
2 bursement, and such detail shall be without
3 interruption or loss of civil service status or
4 privilege.

5 (D) PROCUREMENT OF TEMPORARY AND
6 INTERMITTENT SERVICES.—The Chairperson of
7 the Commission may procure temporary and
8 intermittent services under section 3109(b) of
9 title 5, United States Code, at rates for individ-
10 uals which do not exceed the daily equivalent of
11 the annual rate of basic pay prescribed for level
12 V of the Executive Schedule under section 5316
13 of such title.

14 (g) TERMINATION.—Except with respect to activities
15 in connection with the ongoing biennial report required
16 under subsection (e)(2), the Commission shall terminate
17 90 days after the date on which the Commission submits
18 the report required under subsection (e)(3).

19 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
20 authorized to be appropriated to carry out this section,
21 such sums as may be necessary for fiscal year 2007 and
22 each subsequent fiscal year.



1 **SEC. 182. INSTITUTE OF MEDICINE EVALUATION AND RE-**
2 **PORT ON HEALTH CARE PERFORMANCE**
3 **MEASURES.**

4 (a) EVALUATION.—

5 (1) IN GENERAL.—Not later than the date that
6 is 2 months after the date of the enactment of this
7 Act, the Secretary shall enter into an arrangement
8 under which the Institute of Medicine of the Na-
9 tional Academy of Sciences (in this section referred
10 to as the “Institute”) shall conduct an evaluation of
11 the Federal poverty line for purposes of access to
12 health care services under any applicable Federal
13 health care program.

14 (2) POVERTY LINE DEFINED.—For purposes of
15 paragraph (1), the term “poverty line” has the
16 meaning given that term in section 673(2) of the
17 Community Services Block Grant Act (42 U.S.C.
18 9902(2)), including any revision required by such
19 section.

20 (b) REPORT.—Not later than the date that is 18
21 months after the date of enactment of this Act, the Insti-
22 tute shall submit to the Secretary and appropriate com-
23 mittees of jurisdiction of the House of Representatives and
24 Senate a report on the evaluation conducted under sub-
25 section (a)(1) describing the findings of such evaluation
26 and recommendations for any adjustment of the Federal



1 poverty line for appropriate access of individuals to such
2 Federal health care programs.

3 (c) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated such sums as may be
5 necessary for purposes of conducting the evaluation and
6 preparing the report required by this section.

7 **Subtitle H—FMAP Reimbursement**
8 **for Native Hawaiians**

9 **SEC. 191. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
10 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
11 **A FEDERALLY-QUALIFIED HEALTH CENTER**
12 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
13 **TEM UNDER THE MEDICAID PROGRAM.**

14 (a) MEDICAID.—The third sentence of section
15 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))
16 is amended by inserting “, and with respect to medical
17 assistance provided to a Native Hawaiian (as defined in
18 section 12 of the Native Hawaiian Health Care Improve-
19 ment Act) through a federally-qualified health center or
20 a Native Hawaiian health care system (as so defined)
21 whether directly, by referral, or under contract or other
22 arrangement between a federally-qualified health center or
23 a Native Hawaiian health care system and another health
24 care provider” before the period.



1 (b) EFFECTIVE DATE.—The amendment made by
2 this section applies to medical assistance provided on or
3 after the date of enactment of this Act.

4 **TITLE II—CULTURALLY AND LIN-**
5 **GUISTICALLY APPROPRIATE**
6 **HEALTHCARE**

7 **SEC. 201. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
8 **ACT.**

9 The Public Health Service Act (42 U.S.C. 201 et
10 seq.) is amended by adding at the end the following:

11 **“TITLE XXIX—CULTURALLY AND**
12 **LINGUISTICALLY APPRO-**
13 **PRIATE HEALTHCARE**

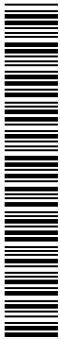
14 **“SEC. 2900. DEFINITIONS.**

15 “In this title:

16 “(1) APPROPRIATE HEALTHCARE SERVICES.—

17 The term ‘appropriate healthcare services’ includes
18 services or treatments to address physical, mental,
19 and behavioral disorders or syndromes.

20 “(2) INDIAN TRIBE.—The term ‘Indian tribe’
21 means any Indian tribe, band, nation, or other orga-
22 nized group or community, including any Alaska Na-
23 tive village or group or regional or village corpora-
24 tion as defined in or established pursuant to the
25 Alaska Native Claims Settlement Act (85 Stat. 688)



1 (43 U.S.C. 1601 et seq.), which is recognized as eli-
2 gible for the special programs and services provided
3 by the United States to Indians because of their sta-
4 tus as Indians.

5 “(3) LIMITED ENGLISH PROFICIENT.—The
6 term ‘limited English proficient’ with respect to an
7 individual means an individual who cannot speak,
8 read, write, or understand the English language at
9 a level that permits them to interact effectively with
10 clinical or nonclinical staff at a healthcare organiza-
11 tion.

12 “(4) MINORITY.—

13 “(A) IN GENERAL.—The terms ‘minority’
14 and ‘minorities’ refer to individuals from a mi-
15 nority group.

16 “(B) POPULATIONS.—The term ‘minority’,
17 with respect to populations, refers to racial and
18 ethnic minority groups.

19 “(5) MINORITY GROUP.—The term ‘minority
20 group’ has the meaning given the term ‘racial and
21 ethnic minority group’.

22 “(6) RACIAL AND ETHNIC MINORITY GROUP.—
23 The term ‘racial and ethnic minority group’ means
24 American Indians and Alaska Natives, African
25 Americans (including Caribbean Blacks and Afri-



1 cans), Asian Americans, Hispanics (including
2 Latinos), and Native Hawaiians and other Pacific
3 Islanders.

4 “(7) STATE.—The term ‘State’ means each of
5 the several states, the District of Columbia, the
6 Commonwealth of Puerto Rico, the Indian tribes,
7 the Virgin Islands, Guam, American Samoa, and the
8 Commonwealth of the Northern Mariana Islands.

9 **“SEC. 2901. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
10 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

11 “(a) PURPOSE.—As provided in Executive Order
12 13166, it is the purpose of this section—

13 “(1) to improve access to Federally conducted
14 and Federally assisted programs and activities for
15 individuals who are limited in their English pro-
16 ficiency;

17 “(2) to require each Federal agency to examine
18 the services it provides and develop and implement
19 a system by which limited English proficient individ-
20 uals can enjoy meaningful access to those services
21 consistent with, and without substantially burdening,
22 the fundamental mission of the agency;

23 “(3) to require each Federal agency to ensure
24 that recipients of Federal financial assistance pro-



1 vide meaningful access to their limited English pro-
2 ficient applicants and beneficiaries;

3 “(4) to ensure that recipients of Federal finan-
4 cial assistance take reasonable steps, consistent with
5 the guidelines set forth in the Limited English Pro-
6 ficient Guidance of the Department of Justice (as
7 issued on June 12, 2002), to ensure meaningful ac-
8 cess to their programs and activities by limited
9 English proficient individuals; and

10 “(5) to ensure compliance with title VI of the
11 Civil Rights Act of 1964 and that healthcare pro-
12 viders and organizations do not discriminate in the
13 provision of services.

14 “(b) FEDERALLY CONDUCTED PROGRAMS AND AC-
15 TIVITIES.—

16 “(1) IN GENERAL.—Not later than 120 days
17 after the date of enactment of this Act, each Federal
18 agency that carries out health care-related activities
19 shall prepare a plan to improve access to the feder-
20 ally conducted health care-related programs and ac-
21 tivities of the agency by limited English proficient
22 individuals.

23 “(2) PLAN REQUIREMENT.—Each plan under
24 paragraph (1) shall be consistent with the standards
25 set forth in section 204 of the Healthcare Equality



1 and Accountability Act, and shall include the steps
2 the agency will take to ensure that limited English
3 proficient individuals have access to the agency's
4 health care-related programs and activities. Each
5 agency shall send a copy of such plan to the Depart-
6 ment of Justice, which shall serve as the central re-
7 pository of the agencies' plans.

8 “(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-
9 TIES.—

10 “(1) IN GENERAL.—Not later than 120 days
11 after the date of enactment of this Act, each Federal
12 agency providing health care-related Federal finan-
13 cial assistance shall ensure that the guidance for re-
14 cipients of Federal financial assistance developed by
15 the agency to ensure compliance with title VI of the
16 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
17 is specifically tailored to the recipients of such as-
18 sistance and is consistent with the standards de-
19 scribed in section 204 of the Healthcare Equality
20 and Accountability Act. Each agency shall send a
21 copy of such guidance to the Department of Justice
22 which shall serve as the central repository of the
23 agencies' plans. After approval by the Department of
24 Justice, each agency shall publish its guidance docu-
25 ment in the Federal Register for public comment.



1 “(2) REQUIREMENTS.—The agency-specific
2 guidance developed under paragraph (1) shall—

3 “(A) detail how the general standards es-
4 tablished under section 204 of the Healthcare
5 Equality and Accountability Act will be applied
6 to the agency’s recipients; and

7 “(B) take into account the types of health
8 care services provided by the recipients, the in-
9 dividuals served by the recipients, and other
10 factors set out in such standards.

11 “(3) EXISTING GUIDANCES.—A Federal agency
12 that has developed a guidance for purposes of title
13 VI of the Civil Rights Act of 1964 that the Depart-
14 ment of Justice determines is consistent with the
15 standards described in section 204 of the Healthcare
16 Equality and Accountability Act shall examine such
17 existing guidance, as well as the programs and ac-
18 tivities to which such guidance applies, to determine
19 if modification of such guidance is necessary to com-
20 ply with this subsection.

21 “(4) CONSULTATION.—Each Federal agency
22 shall consult with the Department of Justice in es-
23 tablishing the guidances under this subsection.

24 “(d) CONSULTATIONS.—



1 “(1) IN GENERAL.—In carrying out this sec-
2 tion, each Federal agency that carries out health
3 care-related activities shall ensure that stakeholders,
4 such as limited English proficient individuals and
5 their representative organizations, recipients of Fed-
6 eral assistance, and other appropriate individuals or
7 entities, have an adequate and comparable oppor-
8 tunity to provide input with respect to the actions of
9 the agency.

10 “(2) EVALUATION.—Each Federal agency de-
11 scribed in paragraph (1) shall evaluate the—

12 “(A) particular needs of the limited
13 English proficient individuals served by the
14 agency, and by a recipient of assistance pro-
15 vided by the agency;

16 “(B) burdens of compliance with the agen-
17 cy guidance and its recipients of the require-
18 ments of this section; and

19 “(C) outcomes or effectiveness of services.

20 **“SEC. 2902. NATIONAL STANDARDS FOR CULTURALLY AND**
21 **LINGUISTICALLY APPROPRIATE SERVICES IN**
22 **HEALTHCARE.**

23 “Recipients of Federal financial assistance from the
24 Secretary shall, to the extent reasonable and practicable
25 after applying the 4-factor analysis described in title V



1 of the Guidance to Federal Financial Assistance Recipi-
2 ents Regarding Title VI Prohibition Against National Ori-
3 gin Discrimination Affecting Limited-English Proficient
4 Persons (June 12, 2002)—

5 “(1) implement strategies to recruit, retain, and
6 promote individuals at all levels of the organization
7 to maintain a diverse staff and leadership that can
8 provide culturally and linguistically appropriate
9 healthcare to patient populations of the service area
10 of the organization;

11 “(2) ensure that staff at all levels and across all
12 disciplines of the organization receive ongoing edu-
13 cation and training in culturally and linguistically
14 appropriate service delivery;

15 “(3) offer and provide language assistance serv-
16 ices, including bilingual staff and interpreter serv-
17 ices, at no cost to each patient with limited English
18 proficiency at all points of contact, in a timely man-
19 ner during all hours of operation;

20 “(4) notify patients of their right to receive lan-
21 guage assistance services in their primary language;

22 “(5) ensure the competence of language assist-
23 ance provided to limited English proficient patients
24 by interpreters and bilingual staff, and ensure that



1 family, particularly minor children, and friends are
2 not used to provide interpretation services—

3 “(A) except in case of emergency; or

4 “(B) except on request of the patient, who
5 has been informed in his or her preferred lan-
6 guage of the availability of free interpretation
7 services;

8 “(6) make available easily understood patient-
9 related materials, if such materials exist for non-lim-
10 ited English proficient patients, including informa-
11 tion or notices about termination of benefits and
12 post signage in the languages of the commonly en-
13 countered groups or groups represented in the serv-
14 ice area of the organization;

15 “(7) develop and implement clear goals, poli-
16 cies, operational plans, and management account-
17 ability and oversight mechanisms to provide cul-
18 turally and linguistically appropriate services;

19 “(8) conduct initial and ongoing organizational
20 assessments of culturally and linguistically appro-
21 priate services-related activities and integrate valid
22 linguistic competence-related measures into the in-
23 ternal audits, performance improvement programs,
24 patient satisfaction assessments, and outcomes-based
25 evaluations of the organization;



1 “(9) ensure that, consistent with the privacy
2 protections provided for under the regulations pro-
3 mulgated under section 264(c) of the Health Insur-
4 ance Portability and Accountability Act of 1996 (42
5 U.S.C. 1320d–2 note)—

6 “(A) data on the individual patient’s race,
7 ethnicity, and primary language are collected in
8 health records, integrated into the organiza-
9 tion’s management information systems, and
10 periodically updated; and

11 “(B) if the patient is a minor or is inca-
12 pacitated, the primary language of the parent
13 or legal guardian is collected;

14 “(10) maintain a current demographic, cultural,
15 and epidemiological profile of the community as well
16 as a needs assessment to accurately plan for and im-
17 plement services that respond to the cultural and
18 linguistic characteristics of the service area of the
19 organization;

20 “(11) develop participatory, collaborative part-
21 nerships with communities and utilize a variety of
22 formal and informal mechanisms to facilitate com-
23 munity and patient involvement in designing and im-
24 plementing culturally and linguistically appropriate
25 services-related activities;



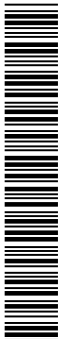
1 “(12) ensure that conflict and grievance resolu-
2 tion processes are culturally and linguistically sen-
3 sitive and capable of identifying, preventing, and re-
4 solving cross-cultural conflicts or complaints by pa-
5 tients;

6 “(13) regularly make available to the public in-
7 formation about their progress and successful inno-
8 vations in implementing the standards under this
9 section and provide public notice in their commu-
10 nities about the availability of this information; and

11 “(14) if requested, regularly make available to
12 the head of each Federal entity from which Federal
13 funds are received, information about their progress
14 and successful innovations in implementing the
15 standards under this section as required by the head
16 of such entity.

17 **“SEC. 2903. ROBERT T. MATSUI CENTER FOR CULTURAL**
18 **AND LINGUISTIC COMPETENCE IN**
19 **HEALTHCARE.**

20 “(a) ESTABLISHMENT.—The Secretary, acting
21 through the Director of the Office of Minority Health,
22 shall establish and support a center to be known as the
23 ‘Robert T. Matsui Center for Cultural and Linguistic
24 Competence in Healthcare’ (referred to in this section as
25 the ‘Center’) to carry out the following activities:



1 “(1) REMOTE MEDICAL INTERPRETING.—The
2 Center shall provide remote medical interpreting, di-
3 rectly or through contracts, to healthcare providers
4 who otherwise would be unable to provide language
5 interpreting services, at reasonable or no cost as de-
6 termined appropriate by the Director of the Center.
7 Methods of interpretation may include remote, si-
8 multaneous or consecutive interpreting through tele-
9 phonic systems, video conferencing, and other meth-
10 ods determined appropriate by the Secretary for pa-
11 tients with limited English proficiency. The quality
12 of such interpreting shall be monitored and reported
13 publicly. Nothing in this paragraph shall be con-
14 strued to limit the ability of healthcare providers or
15 organizations to provide medical interpreting serv-
16 ices directly and obtain reimbursement for such
17 services as provided for under the medicare, med-
18 icaid or SCHIP programs under titles XVIII, XIX,
19 or XXI of the Social Security Act.

20 “(2) MODEL LANGUAGE ASSISTANCE PRO-
21 GRAMS.—The Center shall provide for the collection
22 and dissemination of information on current model
23 language assistance programs and strategies to im-
24 prove language access to healthcare for individuals
25 with limited English proficiency, including case stud-



1 ies using de-identified patient information, program
2 summaries, and program evaluations.

3 “(3) MEDICAL INTERPRETING GUIDELINES.—

4 “(A) IN GENERAL.—The Center shall con-
5 vene a national working group to develop med-
6 ical interpreting and translation guidelines and
7 standards for—

8 “(i) the provision of services;

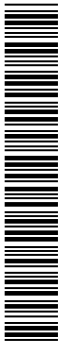
9 “(ii) the actual practice of inter-
10 preting;

11 “(iii) the training of medical inter-
12 preters and translators, developed by inter-
13 preters and translators.

14 “(B) PUBLICATION.—Not later than 18
15 months after the date of enactment of this Act,
16 the Center shall publish guidelines and stand-
17 ards developed under this paragraph in the
18 Federal Register.

19 “(4) INTERNET HEALTH CLEARINGHOUSE.—

20 The Center shall develop and maintain an Internet
21 clearinghouse to reduce medical errors and improve
22 medical outcomes and reduce healthcare costs
23 caused by communication with individuals with lim-
24 ited English proficiency or low functional health lit-



1 eracy and reduce or eliminate the duplication of ef-
2 fort to translate materials by—

3 “(A) developing and making available tem-
4 plates for standard documents that are nec-
5 essary for patients and consumers to access and
6 make educated decisions about their healthcare,
7 including—

8 “(i) administrative and legal docu-
9 ments such as informed consent, advanced
10 directives, and waivers of rights;

11 “(ii) clinical information such as how
12 to take medications, how to prevent trans-
13 mission of a contagious disease, and other
14 prevention and treatment instructions;

15 “(iii) patient education and outreach
16 materials such as immunization notices,
17 health warnings, or screening notices; and

18 “(iv) additional health or healthcare-
19 related materials as determined appro-
20 priate by the Director of the Center;

21 “(B) ensuring that the documents the
22 posted in English and non-English languages
23 and are culturally appropriate;

24 “(C) allowing public review of the docu-
25 ments before dissemination in order to ensure



1 that the documents are understandable and cul-
2 turally appropriate for the target populations;

3 “(D) allowing healthcare providers to cus-
4 tomize the documents for their use;

5 “(E) facilitating access to these docu-
6 ments;

7 “(F) providing technical assistance with
8 respect to the access and use of such informa-
9 tion; and

10 “(G) carrying out any other activities the
11 Secretary determines to be useful to fulfill the
12 purposes of the Clearinghouse.

13 “(5) PROVISION OF INFORMATION.—The Cen-
14 ter shall provide information relating to culturally
15 and linguistically competent healthcare for minority
16 populations residing in the United States to all
17 healthcare providers and healthcare organizations at
18 no cost. Such information shall include—

19 “(A) tenets of culturally and linguistically
20 competent care;

21 “(B) cultural and linguistic competence
22 self-assessment tools;

23 “(C) cultural and linguistic competence
24 training tools;



1 “(D) strategic plans to increase cultural
2 and linguistic competence in different types of
3 healthcare organizations; and

4 “(E) resources for cultural competence in-
5 formation for educators, practitioners and re-
6 searchers.

7 “(b) DIRECTOR.—The Center shall be headed by a
8 Director to be appointed by the Director of the Office of
9 Minority Health who shall report to the Director of the
10 Office of Minority Health.

11 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
12 rector shall collaborate with the Administrator of the Cen-
13 ters for Medicare and Medicaid Services and the Adminis-
14 trator of the Health Resources and Services Administra-
15 tion, to notify healthcare providers and healthcare organi-
16 zations about the availability of language access services
17 by the Center.

18 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section
20 such sums as may be necessary for each of fiscal years
21 2006 through 2011.

22 **“SEC. 2904. INNOVATIONS IN LANGUAGE ACCESS GRANTS.**

23 “(a) IN GENERAL.—The Secretary, acting through
24 the Administrator of the Centers for Medicare and Med-
25 icaid Services, the Administrator of the Health Resources



1 and Services Administration, the Secretary of Education,
2 and the Director of the Office of Minority Health, shall
3 award grants to eligible entities to enable such entities to
4 design, implement, and evaluate innovative, cost-effective
5 programs to improve language access to healthcare for in-
6 dividuals with limited English proficiency.

7 “(b) ELIGIBILITY.—To be eligible to receive a grant
8 under subsection (a) an entity shall—

9 “(1) be a city, county, Indian tribe, State, terri-
10 tory, community-based and other nonprofit organiza-
11 tion, health center or community clinic, university,
12 college, or other entity designated by the Secretary;
13 and

14 “(2) prepare and submit to the Secretary an
15 application, at such time, in such manner, and ac-
16 companied by such additional information as the
17 Secretary may require.

18 “(c) USE OF FUNDS.—An entity shall use funds re-
19 ceived under a grant under this section to—

20 “(1) develop, implement, and evaluate models of
21 providing real-time interpretation services through
22 in-person interpretation, communications, and com-
23 puter technology, including the Internet, teleconfer-
24 encing, or video conferencing;



1 “(2) develop short-term medical interpretation
2 training courses and incentives for bilingual
3 healthcare staff who are asked to interpret in the
4 workplace;

5 “(3) develop formal training programs for indi-
6 viduals interested in becoming dedicated healthcare
7 interpreters;

8 “(4) provide staff language training instruction
9 which shall include information on the practical limi-
10 tations of such instruction for non-native speakers;

11 “(5) provide basic healthcare-related English
12 language instruction for limited English proficient
13 individuals; and

14 “(6) develop other language assistance services
15 as determined appropriate by the Secretary.

16 “(d) PRIORITY.—In awarding grants under this sec-
17 tion, the Secretary shall give priority to entities that have
18 developed partnerships with organizations or agencies with
19 experience in language access services.

20 “(e) EVALUATION.—An entity that receives a grant
21 under this section shall submit to the Secretary an evalua-
22 tion that describes the activities carried out with funds
23 received under the grant, and how such activities improved
24 access to healthcare services and the quality of healthcare
25 for individuals with limited English proficiency. Such eval-



1 uation shall be collected and disseminated through the
2 Center for Linguistic and Cultural Competence in
3 Healthcare established under section 2903.

4 “(f) GRANTEE CONVENTION.—The Secretary, acting
5 through the Director of the Center for Linguistic and Cul-
6 tural Competence in Healthcare, shall at the end of the
7 grant cycle convene grantees under this section to share
8 findings and develop and disseminate model programs and
9 practices.

10 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 such sums as may be necessary for each of fiscal years
13 2006 through 2011.

14 **“SEC. 2905. RESEARCH ON LANGUAGE ACCESS.**

15 “(a) IN GENERAL.—The Director of the Agency for
16 Healthcare Research and Quality, in collaboration with
17 the Director of the Office of Minority Health, shall expand
18 research concerning—

19 “(1) the barriers to healthcare services includ-
20 ing mental and behavioral services that are faced by
21 limited English proficient individuals;

22 “(2) the impact of language barriers on the
23 quality of healthcare and the health status of limited
24 English proficient individuals and populations;



1 “(3) healthcare provider attitudes, knowledge,
2 and awareness of the barriers described in para-
3 graphs (1) and (2);

4 “(4) the means by which language access serv-
5 ices are provided to limited English proficient indi-
6 viduals and how such services are effective in im-
7 proving the quality of care;

8 “(5) the cost-effectiveness of providing language
9 access; and

10 “(6) optimal approaches for delivering language
11 access.

12 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2006 through 2011.

16 **“SEC. 2906. INFORMATION ABOUT FEDERAL HEALTH PRO-**
17 **GRAMS FOR LIMITED ENGLISH PROFICIENT**
18 **POPULATIONS.**

19 “The Secretary shall provide for a means by which
20 limited English proficient individuals who are seeking in-
21 formation about, or assistance with, Federal healthcare
22 programs may obtain such information or assistance.”.

23 **SEC. 202. STANDARDS FOR LANGUAGE ACCESS SERVICES.**

24 Not later than 120 days after the date of enactment
25 of this Act, the head of each Federal agency that carries



1 out health care-related activities shall develop and adopt
2 a guidance on language services for those with limited
3 English proficiency who attempt to have access to or par-
4 ticipate in such activities that provides at the minimum
5 the factors and principles set forth in the Department of
6 Justice guidance published on June 12, 2002.

7 **SEC. 203. FEDERAL REIMBURSEMENT FOR CULTURALLY**
8 **AND LINGUISTICALLY APPROPRIATE SERV-**
9 **ICES UNDER THE MEDICARE, MEDICAID AND**
10 **STATE CHILDREN'S HEALTH INSURANCE**
11 **PROGRAM.**

12 (a) DEMONSTRATION PROJECT PROMOTING ACCESS
13 FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH
14 PROFICIENCY.—

15 (1) IN GENERAL.—The Secretary shall conduct
16 a demonstration project (in this section referred to
17 as the “project”) to demonstrate the impact on costs
18 and health outcomes of providing reimbursement for
19 interpreter services to certain medicare beneficiaries
20 who are limited English proficient in urban and
21 rural areas.

22 (2) SCOPE.—The Secretary shall carry out the
23 project in not less than 30 States through contracts
24 with—



1 (A) health plans (under part C of title
2 XVIII of the Social Security Act);

3 (B) small providers;

4 (C) hospitals; and

5 (D) community-based clinics.

6 (3) DURATION.—Each contract entered into
7 under the project shall extend over a period of not
8 longer than 2 years.

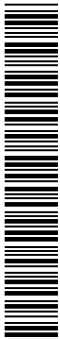
9 (4) REPORT.—Upon completion of the project,
10 the Secretary shall submit a report to Congress on
11 the project which shall include recommendations re-
12 garding the extension of such project to the entire
13 medicare program.

14 (5) EVALUATION.—The Director of the Agency
15 for Healthcare Research and Quality shall award
16 grants to public and private nonprofit entities for
17 the evaluation of the project. Such evaluations shall
18 focus on access, utilization, efficiency, cost-effective-
19 ness, patient satisfaction, and select health out-
20 comes.

21 (b) MEDICAID.—Section 1903(a)(3) of the Social Se-
22 curity Act (42 U.S.C. 1396b(a)(3)) is amended—

23 (1) in subparagraph (D), by striking “plus” at
24 the end and inserting “and”; and

25 (2) by adding at the end the following:



1 “(E) 90 percent of the sums expended with
2 respect to costs incurred during such quarter as
3 are attributable to the provision of culturally
4 and linguistically appropriate services, including
5 oral interpretation, translations of written ma-
6 terials, and other cultural and linguistic services
7 for individuals with limited English proficiency
8 and disabilities who apply for, or receive, med-
9 ical assistance under the State plan (including
10 any waiver granted to the State plan); plus”.

11 (c) SCHIP.—Section 2105(a)(1) of the Social Secu-
12 rity Act (42 U.S.C.1397ee(a)), as amended by section
13 515, is amended—

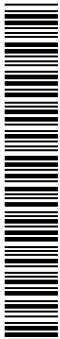
14 (1) in the matter preceding subparagraph (A),
15 by inserting “or, in the case of expenditures de-
16 scribed in subparagraph (D)(iv), 90 percent” after
17 “enhanced FMAP”; and

18 (2) in subparagraph (D)—

19 (A) in clause (iii), by striking “and” at the
20 end;

21 (B) by redesignating clause (iv) as clause
22 (v); and

23 (C) by inserting after clause (iii) the fol-
24 lowing:



1 “(iv) for expenditures attributable to
2 the provision of culturally and linguistically
3 appropriate services, including oral inter-
4 pretation, translations of written materials,
5 and other language services for individuals
6 with limited English proficiency and dis-
7 abilities who apply for, or receive, child
8 health assistance under the plan; and”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section take effect on October 1, 2006.

11 **SEC. 204. INCREASING UNDERSTANDING OF HEALTH LIT-**
12 **ERACY.**

13 (a) IN GENERAL.—The Secretary, acting through the
14 Director of the Agency for Healthcare Research and Qual-
15 ity and the Administrator of the Health Resources and
16 Services Administration, shall award grants to eligible en-
17 tities to improve healthcare for patient populations that
18 have low functional health literacy.

19 (b) ELIGIBILITY.—To be eligible to receive a grant
20 under subsection (a), an entity shall—

21 (1) be a hospital, health center or clinic, health
22 plan, or other health entity; and

23 (2) prepare and submit to the Secretary an ap-
24 plication at such time, in such manner, and con-



1 taining such information as the Secretary may re-
2 quire.

3 (c) USE OF FUNDS.—

4 (1) AGENCY FOR HEALTHCARE RESEARCH AND
5 QUALITY.—Grants awarded under subsection (a)
6 through the Agency for Healthcare Research and
7 Quality shall be used—

8 (A) to define and increase the under-
9 standing of health literacy;

10 (B) to investigate the correlation between
11 low health literacy and health and healthcare;

12 (C) to clarify which aspects of health lit-
13 eracy have an effect on health outcomes; and

14 (D) for any other activity determined ap-
15 propriate by the Director of the Agency.

16 (2) HEALTH RESOURCES AND SERVICES ADMIN-
17 ISTRATION.—Grants awarded under subsection (a)
18 through the Health Resources and Services Adminis-
19 tration shall be used to conduct demonstration
20 projects for interventions for patients with low
21 health literacy that may include—

22 (A) the development of new disease man-
23 agement programs for patients with low health
24 literacy;



1 (B) the tailoring of existing disease man-
2 agement programs addressing mental and phys-
3 ical health conditions for patients with low
4 health literacy;

5 (C) the translation of written health mate-
6 rials for patients with low health literacy;

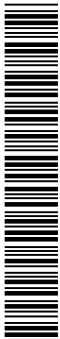
7 (D) the identification, implementation, and
8 testing of low health literacy screening tools;

9 (E) the conduct of educational campaigns
10 for patients and providers about low health lit-
11 eracy; and

12 (F) other activities determined appropriate
13 by the Administrator of the Health Resources
14 and Services Administration.

15 (d) DEFINITIONS.—In this section, the term “low
16 health literacy” means the inability of an individual to ob-
17 tain, process, and understand basic health information
18 and services needed to make appropriate health decisions.

19 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
20 authorized to be appropriated to carry out this section,
21 such sums as may be necessary for each of fiscal years
22 2006 through 2011.



1 **SEC. 205. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
2 **TURALLY AND LINGUISTICALLY APPRO-**
3 **PRIATE HEALTHCARE SERVICES.**

4 Not later than 1 year after the date of enactment
5 of this Act and annually thereafter, the Secretary of
6 Health and Human Services shall enter into a contract
7 with the Institute of Medicine for the preparation and
8 publication of a report that describes federal efforts to en-
9 sure that all individuals have meaningful access to cul-
10 turally and linguistically appropriate healthcare services.
11 Such report shall include—

12 (1) a description and evaluation of the activities
13 carried out under this Act; and

14 (2) a description of best practices, model pro-
15 grams, guidelines, and other effective strategies for
16 providing access to culturally and linguistically ap-
17 propriate healthcare services.

18 **SEC. 206. GENERAL ACCOUNTING OFFICE REPORT ON IM-**
19 **PACT OF LANGUAGE ACCESS SERVICES.**

20 Not later than 3 years after the date of enactment
21 of this Act, the Comptroller General of the United States
22 shall examine, and prepare and publish a report on, the
23 impact of language access services on the health and
24 healthcare of limited English proficient populations. Such
25 report shall include—



1 (1) recommendations on the development and
2 implementation of policies and practices by
3 healthcare organizations and providers for limited
4 English proficient patient populations;

5 (2) a description of the effect of providing lan-
6 guage access services on quality of healthcare and
7 access to care and reduced medical error; and

8 (3) a description of the costs associated with or
9 savings related to provision of language access serv-
10 ices.

11 **SEC. 207. DEFINITIONS.**

12 In this title:

13 (1) INCORPORATED DEFINITIONS.—The defini-
14 tions contained in section 2900 of the Public Health
15 Service Act, as added by section 201, shall apply.

16 (2) SECRETARY.—The term “Secretary” means
17 the Secretary of Health and Human Services.

18 **TITLE III—HEALTH WORKFORCE**
19 **DIVERSITY**

20 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
21 **ACT.**

22 Title XXIX of the Public Health Service Act, as
23 added by section 201, is amended by adding at the end
24 the following:



1 **“Subtitle A—Diversifying the**
2 **Healthcare Workplace**

3 **“SEC. 2911. REPORT ON WORKFORCE DIVERSITY.**

4 “(a) IN GENERAL.—Not later than July 1, 2006, and
5 biannually thereafter, the Secretary, acting through the
6 director of each entity within the Department of Health
7 and Human Services, shall prepare and submit to the
8 Committee on Health, Education, Labor, and Pensions of
9 the Senate and the Committee on Energy and Commerce
10 of the House of Representatives a report on health work-
11 force diversity.

12 “(b) REQUIREMENT.—The report under subsection
13 (a) shall contain the following information:

14 “(1) A description of any grant support that is
15 provided by each entity for workforce diversity ini-
16 tiatives with the following information—

17 “(A) the number of grants made;

18 “(B) the purpose of the grants;

19 “(C) the populations served through the
20 grants;

21 “(D) the organizations and institutions re-
22 ceiving the grants; and

23 “(E) the tracking efforts that were used to
24 follow the progress of participants.



1 “(2) A description of the entity’s plan to
2 achieve workforce diversity goals that includes, to
3 the extent relevant to such entity—

4 “(A) the number of underrepresented mi-
5 nority health professionals that will be needed
6 in various disciplines over the next 10 years to
7 achieve population parity;

8 “(B) the level of funding needed to fully
9 expand and adequately support health profes-
10 sions pipeline programs;

11 “(C) the impact such programs have had
12 on the admissions practices and policies of
13 health professions schools;

14 “(D) the management strategy necessary
15 to effectively administer and institutionalize
16 health profession pipeline programs; and

17 “(E) the impact that the Government Per-
18 formance and Results Act (GPRA) has had on
19 evaluating the performance of grantees and
20 whether the GPRA is the best assessment tool
21 for programs under titles VII and VIII.

22 “(3) A description of measurable objectives of
23 each entity relating to workforce diversity initiatives.



1 “(c) PUBLIC AVAILABILITY.—The report under sub-
2 section (a) shall be made available for public review and
3 comment.

4 **“SEC. 2912. NATIONAL WORKING GROUP ON WORKFORCE**
5 **DIVERSITY.**

6 “(a) IN GENERAL.—The Secretary, acting through
7 the Bureau of Health Professions within the Health Re-
8 sources and Services Administration, shall award a grant
9 to an entity determined appropriate by the Secretary for
10 the establishment of a national working group on work-
11 force diversity.

12 “(b) REPRESENTATION.—In establishing the national
13 working group under subsection (a), the grantee shall en-
14 sure that the group has representation from the following
15 entities:

16 “(1) The Health Resources and Services Ad-
17 ministration.

18 “(2) The Department of Health and Human
19 Services Data Council.

20 “(3) The Office of Minority Health.

21 “(4) The Bureau of Labor Statistics of the De-
22 partment of Labor.

23 “(5) The Public Health Practice Program Of-
24 fice—Office of Workforce Policy and Planning.



1 “(6) The National Center on Minority Health
2 and Health Disparities.

3 “(7) The Agency for Healthcare Research and
4 Quality.

5 “(8) The Institute of Medicine Study Com-
6 mittee for the 2004 workforce diversity report.

7 “(9) The Indian Health Service.

8 “(10) Academic institutions.

9 “(11) Consumer organizations.

10 “(12) Health professional associations, includ-
11 ing those that represent underrepresented minority
12 populations.

13 “(13) Researchers in the area of health work-
14 force.

15 “(14) Health workforce accreditation entities.

16 “(15) Private foundations that have sponsored
17 workforce diversity initiatives.

18 “(16) Not less than 5 health professions stu-
19 dents representing various health profession fields
20 and levels of training.

21 “(c) ACTIVITIES.—The working group established
22 under subsection (a) shall convene at least twice each year
23 to complete the following activities:

24 “(1) Review current public and private health
25 workforce diversity initiatives.



1 “(2) Identify successful health workforce diver-
2 sity programs and practices.

3 “(3) Examine challenges relating to the devel-
4 opment and implementation of health workforce di-
5 versity initiatives.

6 “(4) Draft a national strategic work plan for
7 health workforce diversity, including recommenda-
8 tions for public and private sector initiatives.

9 “(5) Develop a framework and methods for the
10 evaluation of current and future health workforce di-
11 versity initiatives.

12 “(6) Develop recommended standards for work-
13 force diversity that could be applicable to all health
14 professions programs and programs funded under
15 this Act.

16 “(7) Develop curriculum guidelines for diversity
17 training.

18 “(8) Develop a strategy for the inclusion of
19 community members on admissions committees for
20 health profession schools.

21 “(9) Other activities determined appropriate by
22 the Secretary.

23 “(d) ANNUAL REPORT.—Not later than 1 year after
24 the establishment of the working group under subsection
25 (a), and annually thereafter, the working group shall pre-



1 pare and make available to the general public for com-
2 ment, an annual report on the activities of the working
3 group. Such report shall include the recommendations of
4 the working group for improving health workforce diver-
5 sity.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section,
8 such sums as may be necessary for each of fiscal years
9 2007 through 2012.

10 **“SEC. 2913. TECHNICAL CLEARINGHOUSE FOR HEALTH**
11 **WORKFORCE DIVERSITY.**

12 “(a) IN GENERAL.—The Secretary, acting through
13 the Office of Minority Health, and in collaboration with
14 the Bureau of Health Professions within the Health Re-
15 sources and Services Administration, shall establish a
16 technical clearinghouse on health workforce diversity with-
17 in the Office of Minority Health and coordinate current
18 and future clearinghouses.

19 “(b) INFORMATION AND SERVICES.—The clearing-
20 house established under subsection (a) shall offer the fol-
21 lowing information and services:

22 “(1) Information on the importance of health
23 workforce diversity.



1 “(2) Statistical information relating to under-
2 represented minority representation in health and al-
3 lied health professions and occupations.

4 “(3) Model health workforce diversity practices
5 and programs.

6 “(4) Admissions policies that promote health
7 workforce diversity and are in compliance with Fed-
8 eral and State laws.

9 “(5) Lists of scholarship, loan repayment, and
10 loan cancellation grants as well as fellowship infor-
11 mation for underserved populations for health pro-
12 fessions schools.

13 “(6) Foundation and other large organizational
14 initiatives relating to health workforce diversity.

15 “(c) CONSULTATION.—In carrying out this section,
16 the Secretary shall consult with non-Federal entities which
17 may include minority health professional associations to
18 ensure the adequacy and accuracy of information.

19 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section,
21 such sums as may be necessary for each of fiscal years
22 2007 through 2012.



1 **“SEC. 2914. EVALUATION OF WORKFORCE DIVERSITY INI-**
2 **TIATIVES.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Bureau of Health Professions within the Health Re-
5 sources and Services Administration, shall award grants
6 to eligible entities for the conduct of an evaluation of cur-
7 rent health workforce diversity initiatives funded by the
8 Department of Health and Human Services.

9 “(b) ELIGIBILITY.—To be eligible to receive a grant
10 under subsection (a) an entity shall—

11 “(1) be a city, county, Indian tribe, State, terri-
12 tory, community-based nonprofit organization,
13 health center, university, college, or other entity de-
14 termined appropriate by the Secretary;

15 “(2) with respect to an entity that is not an
16 academic medical center, university, or private re-
17 search institution, carry out activities under the
18 grant in partnership with an academic medical cen-
19 ter, university, or private research institution; and

20 “(3) submit to the Secretary an application at
21 such time, in such manner, and containing such in-
22 formation as the Secretary may require.

23 “(c) USE OF FUNDS.—Amounts awarded under a
24 grant under subsection (a) shall be used to support the
25 following evaluation activities:



1 “(1) Determinations of measures of health
2 workforce diversity success.

3 “(2) The short- and long-term tracking of par-
4 ticipants in health workforce diversity pipeline pro-
5 grams funded by the Department of Health and
6 Human Services.

7 “(3) Assessments of partnerships formed
8 through activities to increase health workforce diver-
9 sity.

10 “(4) Assessments of barriers to health work-
11 force diversity.

12 “(5) Assessments of policy changes at the Fed-
13 eral, State, and local levels.

14 “(6) Assessments of coordination within and be-
15 tween Federal agencies and other institutions.

16 “(7) Other activities determined appropriate by
17 the Secretary and the Working Group established
18 under section 2912.

19 “(d) REPORT.—Not later than 1 year after the date
20 of enactment of this title, the Bureau of Health Profes-
21 sions within the Health Resources and Services Adminis-
22 tration shall prepare and make available for public com-
23 ment a report that summarizes the findings made by enti-
24 ties under grants under this section.



1 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section,
3 such sums as may be necessary for each of fiscal years
4 2007 through 2012.

5 **“SEC. 2915. DATA COLLECTION AND REPORTING BY**
6 **HEALTH PROFESSIONAL SCHOOLS.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Bureau of Health Professions of the Health Resources
9 and Services Administration and the Office of Minority
10 Health, shall establish an aggregated database on health
11 professional students.

12 “(b) REQUIREMENT TO COLLECT DATA.—Each
13 health professional school (including medical, dental, and
14 nursing schools) and allied health profession school and
15 program that receives Federal funds shall collect race, eth-
16 nicity, and language proficiency data concerning those stu-
17 dents enrolled at such schools or in such programs. In col-
18 lecting such data, a school or program shall—

19 “(1) at a minimum, use the categories for race
20 and ethnicity described in the 1997 Office of Man-
21 agement and Budget Standards for Maintaining,
22 Collecting, and Presenting Federal Data on Race
23 and Ethnicity and available language standards; and



“(2) if practicable, collect data on additional
population groups if such data can be aggregated
into the minimum race and ethnicity data categories.

“(c) USE OF DATA.—Data on race, ethnicity, and primary language collected under this section shall be reported to the database established under subsection (a) on an annual basis. Such data shall be available for public use.

9 “(d) **PRIVACY.**—The Secretary shall ensure that all
10 data collected under this section is protected from inap-
11 propriate internal and external use by any entity that col-
12 lects, stores, or receives the data and that such data is
13 collected without personally identifiable information.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2007 through 2012.

18 **“SEC. 2916. SUPPORT FOR INSTITUTIONS COMMITTED TO**
19 **WORKFORCE DIVERSITY.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration, shall award grants to eligible entities that
23 demonstrate a commitment to health workforce diversity.

24 “(b) ELIGIBILITY.—To be eligible to receive a grant
25 under subsection (a), an entity shall—



1 “(1) be an educational institution or entity that
2 historically produces or trains meaningful numbers
3 of underrepresented minority health professionals,
4 including—

5 “(A) Historically Black Colleges and Uni-
6 versities;

7 “(B) Hispanic-Serving Health Professions
8 Schools;

9 “(C) Hispanic-Serving Institutions;

10 “(D) Tribal Colleges and Universities;

11 “(E) Asian American and Pacific Islander-
12 serving institutions;

13 “(F) institutions that have programs to re-
14 cruit and retain underrepresented minority
15 health professionals, in which a significant
16 number of the enrolled participants are under-
17 represented minorities;

18 “(G) health professional associations,
19 which may include underrepresented minority
20 health professional associations; and

21 “(H) institutions—

22 “(i) located in communities with pre-
23 dominantly underrepresented minority pop-
24 ulations;



1 “(ii) with whom partnerships have
2 been formed for the purpose of increasing
3 workforce diversity; and

4 “(iii) in which at least 20 percent of
5 the enrolled participants are underrep-
6 resented minorities; and

7 “(2) submit to the Secretary an application at
8 such time, in such manner, and containing such in-
9 formation as the Secretary may require.

10 “(c) USE OF FUNDS.—Amounts received under a
11 grant under subsection (a) shall be used to expand existing
12 workforce diversity programs, implement new workforce
13 diversity programs, or evaluate existing or new workforce
14 diversity programs, including with respect to mental
15 health care professions. Such programs shall enhance di-
16 versity by considering minority status as part of an indi-
17 vidualized consideration of qualifications. Possible activi-
18 ties may include—

19 “(1) educational outreach programs relating to
20 opportunities in the health professions;

21 “(2) scholarship, fellowship, grant, loan repay-
22 ment, and loan cancellation programs;

23 “(3) post-baccalaureate programs;



1 “(4) academic enrichment programs, particu-
2 larly targeting those who would not be competitive
3 for health professions schools;

4 “(5) kindergarten through 12th grade and
5 other health pipeline programs;

6 “(6) mentoring programs;

7 “(7) internship or rotation programs involving
8 hospitals, health systems, health plans and other
9 health entities;

10 “(8) community partnership development for
11 purposes relating to workforce diversity; or

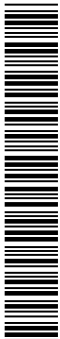
12 “(9) leadership training.

13 “(d) REPORTS.—Not later than 1 year after receiving
14 a grant under this section, and annually for the term of
15 the grant, a grantee shall submit to the Secretary a report
16 that summarizes and evaluates all activities conducted
17 under the grant.

18 “(e) DEFINITION.—In this section, the term ‘Asian
19 American and Pacific Islander-serving institutions’ means
20 institutions—

21 “(1) that are eligible institutions under section
22 312(b) of the Higher Education Act of 1965; and

23 “(2) that, at the time of their application, have
24 an enrollment of undergraduate students that is



1 made up of at least 10 percent Asian American and
2 Pacific Islander students.

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2007 through 2012.

7 **“SEC. 2917. CAREER DEVELOPMENT FOR SCIENTISTS AND**
8 **RESEARCHERS.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Director of the National Institutes of Health, the Di-
11 rector of the Centers for Disease Control and Prevention,
12 the Commissioner of Food and Drugs, and the Director
13 of the Agency for Healthcare Research and Quality, shall
14 award grants that expand existing opportunities for sci-
15 entists and researchers and promote the inclusion of
16 underrepresented minorities in the health professions.

17 “(b) RESEARCH FUNDING.—The head of each entity
18 within the Department of Health and Human Services
19 shall establish or expand existing programs to provide re-
20 search funding to scientists and researchers in-training.
21 Under such programs, the head of each such entity shall
22 give priority in allocating research funding to support
23 health research in traditionally underserved communities,
24 including underrepresented minority communities, and re-
25 search classified as community or participatory.



1 “(c) DATA COLLECTION.—The head of each entity
2 within the Department of Health and Human Services
3 shall collect data on the number (expressed as an absolute
4 number and a percentage) of underrepresented minority
5 and nonminority applicants who receive and are denied
6 agency funding at every stage of review. Such data shall
7 be reported annually to the Secretary and the appropriate
8 committees of Congress.

9 “(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
10 retary shall establish a student loan reimbursement pro-
11 gram to provide student loan reimbursement assistance to
12 researchers who focus on racial and ethnic disparities in
13 health. The Secretary shall promulgate regulations to de-
14 fine the scope and procedures for the program under this
15 subsection.

16 “(e) STUDENT LOAN CANCELLATION.—The Sec-
17 retary shall establish a student loan cancellation program
18 to provide student loan cancellation assistance to research-
19 ers who focus on racial and ethnic disparities in health.
20 Students participating in the program shall make a min-
21 imum 5-year commitment to work at an accredited health
22 profession school. The Secretary shall promulgate addi-
23 tional regulations to define the scope and procedures for
24 the program under this subsection.



1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section,
3 such sums as may be necessary for each of fiscal years
4 2007 through 2012.

5 **“SEC. 2918. CAREER SUPPORT FOR NON-RESEARCH**
6 **HEALTH PROFESSIONALS.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Director of the Centers for Disease Control and Pre-
9 vention, the Administrator of the Substance Abuse and
10 Mental Health Services Administration, the Administrator
11 of the Health Resources and Services Administration, and
12 the Administrator of the Centers for Medicare and Med-
13 icaid Services shall establish a program to award grants
14 to eligible individuals for career support in non-research-
15 related healthcare.

16 “(b) ELIGIBILITY.—To be eligible to receive a grant
17 under subsection (a) an individual shall—

18 “(1) be a student in a health professions school,
19 a graduate of such a school who is working in a
20 health profession, or a faculty member of such a
21 school; and

22 “(2) submit to the Secretary an application at
23 such time, in such manner, and containing such in-
24 formation as the Secretary may require.



1 “(c) USE OF FUNDS.—An individual shall use
2 amounts received under a grant under this section to—

3 “(1) support the individual’s health activities or
4 projects that involve underserved communities, in-
5 cluding racial and ethnic minority communities;

6 “(2) support health-related career advancement
7 activities; and

8 “(3) to pay, or as reimbursement for payments
9 of, student loans for individuals who are health pro-
10 fessionals and are focused on health issues affecting
11 underserved communities, including racial and eth-
12 nic minority communities.

13 “(d) DEFINITION.—In this section, the term ‘career
14 in non-research-related healthcare’ means employment or
15 intended employment in the field of public health, health
16 policy, health management, health administration, medi-
17 cine, nursing, pharmacy, allied health, community health,
18 or other fields determined appropriate by the Secretary,
19 other than in a position that involves research.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 such sums as may be necessary for each of fiscal years
23 2007 through 2012.



1 **“SEC. 2919. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
2 **VERSITY ON QUALITY.**

3 “(a) IN GENERAL.—The Director of the Agency for
4 Healthcare Research and Quality, in collaboration with
5 the Director of the Office of Minority Health and the Di-
6 rector of the National Center on Minority Health and
7 Health Disparities, shall award grants to eligible entities
8 to expand research on the link between health workforce
9 diversity and quality healthcare.

10 “(b) ELIGIBILITY.—To be eligible to receive a grant
11 under subsection (a) an entity shall—

12 “(1) be a clinical, public health, or health serv-
13 ices research entity or other entity determined ap-
14 propriate by the Director; and

15 “(2) submit to the Secretary an application at
16 such time, in such manner, and containing such in-
17 formation as the Secretary may require.

18 “(c) USE OF FUNDS.—Amounts received under a
19 grant awarded under subsection (a) shall be used to sup-
20 port research that investigates the effect of health work-
21 force diversity on—

22 “(1) language access;

23 “(2) cultural competence;

24 “(3) patient satisfaction;

25 “(4) timeliness of care;

26 “(5) safety of care;



1 “(6) effectiveness of care;
2 “(7) efficiency of care;
3 “(8) patient outcomes;
4 “(9) community engagement;
5 “(10) resource allocation;
6 “(11) organizational structure; or
7 “(12) other topics determined appropriate by
8 the Director.

9 “(d) PRIORITY.—In awarding grants under sub-
10 section (a), the Director shall give individualized consider-
11 ation to all relevant aspects of the applicant’s background.
12 Consideration of prior research experience involving the
13 health of underserved communities shall be such a factor.
14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section,
16 such sums as may be necessary for each of fiscal years
17 2007 through 2012.

18 **“SEC. 2920. HEALTH DISPARITIES EDUCATION PROGRAM.**

19 “(a) ESTABLISHMENT.—The Secretary, acting
20 through the National Center on Minority Health and
21 Health Disparities and in collaboration with the Office of
22 Minority Health, the Office for Civil Rights, the Centers
23 for Disease Control and Prevention, the Centers for Medi-
24 care and Medicaid Services, the Health Resources and
25 Services Administration, and other appropriate public and



1 private entities, shall establish and coordinate a health and
2 healthcare disparities education program to support, de-
3 velop, and implement educational initiatives and outreach
4 strategies that inform healthcare professionals and the
5 public about the existence of and methods to reduce racial
6 and ethnic disparities in health and healthcare.

7 “(b) ACTIVITIES.—The Secretary, through the edu-
8 cation program established under subsection (a) shall,
9 through the use of public awareness and outreach cam-
10 paigns targeting the general public and the medical com-
11 munity at large—

12 “(1) disseminate scientific evidence for the ex-
13 istence and extent of racial and ethnic disparities in
14 healthcare, including disparities that are not other-
15 wise attributable to known factors such as access to
16 care, patient preferences, or appropriateness of
17 intervention, as described in the 2002 Institute of
18 Medicine Report, Unequal Treatment;

19 “(2) disseminate new research findings to
20 healthcare providers and patients to assist them in
21 understanding, reducing, and eliminating health and
22 healthcare disparities;

23 “(3) disseminate information about the impact
24 of linguistic and cultural barriers on healthcare qual-
25 ity and the obligation of health providers who receive



1 Federal financial assistance to ensure that people
2 with limited English proficiency have access to lan-
3 guage access services;

4 “(4) disseminate information about the impor-
5 tance and legality of racial, ethnic, and primary lan-
6 guage data collection, analysis, and reporting;

7 “(5) design and implement specific educational
8 initiatives to health care providers relating to health
9 and health care disparities;

10 “(6) assess the impact of the programs estab-
11 lished under this section in raising awareness of
12 health and healthcare disparities and providing in-
13 formation on available resources.

14 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section,
16 such sums as may be necessary for each of fiscal years
17 2007 through 2012.

18 **“SEC. 2920A. CULTURAL COMPETENCE TRAINING FOR**
19 **HEALTHCARE PROFESSIONALS.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration, the Director of the Office of Minority
23 Health, and the Director of the National Center for Mi-
24 nority Health and Health Disparities, shall award grants
25 to eligible entities to test, implement, and evaluate models



1 of cultural competence training, including continuing edu-
2 cation, for healthcare providers in coordination with the
3 initiative under section 2920(a).

4 “(b) ELIGIBILITY.—To be eligible to receive a grant
5 under subsection (a), an entity shall—

6 “(1) be an academic medical center, a health
7 center or clinic, a hospital, a health plan, a health
8 system, or a health care professional guild (including
9 a mental health care professional guild);

10 “(2) partner with a minority serving institution,
11 minority professional association, or community-
12 based organization representing minority popu-
13 lations, in addition to a research institution to carry
14 out activities under this grant; and

15 “(3) prepare and submit to the Secretary an
16 application at such time, in such manner, and con-
17 taining such information as the Secretary may re-
18 quire.

19 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section,
21 such sums as may be necessary for each of fiscal years
22 2007 through 2012.”.

23 **SEC. 302. HEALTH CAREERS OPPORTUNITY PROGRAM.**

24 (a) PURPOSE.—It is the purpose of this section to
25 diversify the healthcare workforce by increasing the num-



1 ber of individuals from disadvantaged backgrounds in the
2 health and allied health professions by enhancing the aca-
3 demic skills of students from disadvantaged backgrounds
4 and supporting them in successfully competing, entering,
5 and graduating from health professions training pro-
6 grams.

7 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
8 740(c) of the Public Health Service Act (42 U.S.C.
9 293d(c)) is amended by striking “\$29,400,000” and all
10 that follows through “2002” and inserting “\$50,000,000
11 for fiscal year 2007, and such sums as may be necessary
12 for each of fiscal years 2008 through 2012”.

13 **SEC. 303. PROGRAM OF EXCELLENCE IN HEALTH PROFES-**
14 **SIONS EDUCATION FOR UNDERREP-**
15 **RESENTED MINORITIES.**

16 (a) PURPOSE.—It is the purpose of this section to
17 diversify the healthcare workforce by supporting programs
18 of excellence in designated health professions schools that
19 demonstrate a commitment to underrepresented minority
20 populations with a focus on minority health issues, cul-
21 tural and linguistic competence, and eliminating health
22 disparities.

23 (b) AUTHORIZATION OF APPROPRIATION.—Section
24 737(h)(1) of the Public Health Service Act (42 U.S.C.
25 293(h)(1)) is amended to read as follows:



1 “(1) AUTHORIZATION OF APPROPRIATIONS.—
2 For the purpose of making grants under subsection
3 (a), there are authorized to be appropriated
4 \$50,000,000 for fiscal year 2007, and such sums as
5 may be necessary for each of the fiscal years 2008
6 through 2012.”.

7 **SEC. 304. HISPANIC-SERVING HEALTH PROFESSIONS**
8 **SCHOOLS.**

9 Part B of title VII of the Public Health Service Act
10 (42 U.S.C. 293 et seq.) is amended by adding at the end
11 the following:

12 **“SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS**
13 **SCHOOLS.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Administrator of the Health Resources and Services
16 Administration, shall award grants to Hispanic-serving
17 health professions schools for the purpose of carrying out
18 programs to recruit Hispanic individuals to enroll in and
19 graduate from such schools, which may include providing
20 scholarships and other financial assistance as appropriate.

21 “(b) ELIGIBILITY.—In subsection (a), the term ‘His-
22 panic-serving health professions school’ means an entity
23 that—

24 “(1) is a school or program under section
25 799B;



1 “(2) has an enrollment of full-time equivalent
2 students that is made up of at least 9 percent His-
3 panic students;

4 “(3) has been effective in carrying out pro-
5 grams to recruit Hispanic individuals to enroll in
6 and graduate from the school;

7 “(4) has been effective in recruiting and retain-
8 ing Hispanic faculty members; and

9 “(5) has a significant number of graduates who
10 are providing health services to medically under-
11 served populations or to individuals in health profes-
12 sional shortage areas.”.

13 **SEC. 305. HEALTH PROFESSIONS STUDENT LOAN FUND; AU-**
14 **THORIZATIONS OF APPROPRIATIONS RE-**
15 **GARDING STUDENTS FROM DISADVANTAGED**
16 **BACKGROUNDS.**

17 Section 724(f)(1) of the Public Health Service Act
18 (42 U.S.C. 292t(f)(1)) is amended by striking
19 “\$8,000,000” and all that follows and inserting
20 “\$35,000,000 for fiscal year 2007, and such sums as may
21 be necessary for each of the fiscal years 2008 through
22 2012.”.



1 **SEC. 306. NATIONAL HEALTH SERVICE CORPS; RECRUIT-**
2 **MENT AND FELLOWSHIPS FOR INDIVIDUALS**
3 **FROM DISADVANTAGED BACKGROUNDS.**

4 (a) IN GENERAL.—Section 331(b) of the Public
5 Health Service Act (42 U.S.C. 254d(b)) is amended by
6 adding at the end the following:

7 “(3) The Secretary shall ensure that the individuals
8 with respect to whom activities under paragraphs (1) and
9 (2) are carried out include individuals from disadvantaged
10 backgrounds, including activities carried out to provide
11 health professions students with information on the Schol-
12 arship and Repayment Programs.”.

13 (b) ASSIGNMENT OF CORPS PERSONNEL.—Section
14 333(a) of the Public Health Service Act (42 U.S.C.
15 254f(a)) is amended by adding at the end the following:

16 “(4) In assigning Corps personnel under this section,
17 the Secretary shall give preference to applicants who re-
18 quest assignment to a federally qualified health center (as
19 defined in section 1905(l)(2)(B) of the Social Security
20 Act) or to a provider organization that has a majority of
21 patients who are minorities or individuals from low-income
22 families (families with a family income that is less than
23 200 percent of the Official Poverty Line).”.



1 **SEC. 307. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
2 **DISEASE CONTROL AND PREVENTION.**

3 Section 317F(c) of the Public Health Service Act (42
4 U.S.C. 247b–7(c)) is amended—

5 (1) by striking “and” after “1994,”; and

6 (2) by inserting before the period the following:

7 “\$750,000 for fiscal year 2007, and such sums as
8 may be necessary for each of the fiscal years 2008
9 through 2012.”.

10 **SEC. 308. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
11 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
12 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

13 Part B of title VII of the Public Health Service Act
14 (42 U.S.C. 293 et seq.), as amended by section 304, is
15 further amended by adding at the end the following:

16 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
17 **GREE PROGRAMS.**

18 “(a) COOPERATIVE AGREEMENTS.—The Secretary,
19 acting through the Administrator of the Health Resources
20 and Services Administration, in consultation with the Di-
21 rector of the Centers for Disease Control and Prevention,
22 the Director of the Agency for Healthcare Research and
23 Quality, and the Director of the Office of Minority Health,
24 shall award cooperative agreements to schools of public
25 health and schools of allied health to design and imple-
26 ment online degree programs.



1 “(b) PRIORITY.—In awarding cooperative agreements
2 under this section, the Secretary shall give priority to any
3 school of public health or school of allied health that has
4 an established track record of serving medically under-
5 served communities.

6 “(c) REQUIREMENTS.—Awardees must design and
7 implement an online degree program, that meet the fol-
8 lowing restrictions:

9 “(1) Enrollment of individuals who have ob-
10 tained a secondary school diploma or its recognized
11 equivalent.

12 “(2) Maintaining a significant enrollment of
13 underrepresented minority or disadvantaged stu-
14 dents.

15 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section,
17 such sums as may be necessary for each of fiscal years
18 2007 through 2012.”.

19 **SEC. 309. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
20 **SHIP PROGRAM.**

21 Part B of title VII of the Public Health Service Act
22 (as amended by section 308) is further amended by adding
23 at the end the following:



1 **“SEC. 744. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
2 **SHIP PROGRAM.**

3 “(a) IN GENERAL.—The Secretary may make grants
4 to eligible schools for awarding scholarships to eligible in-
5 dividuals to attend the school involved, for the purpose of
6 enabling the individuals to make a career change from a
7 non-health profession to a health profession.

8 “(b) EXPENSES.—Amounts awarded as a scholarship
9 under this section—

10 “(1) subject to paragraph (2), may be expended
11 only for tuition expenses, other reasonable edu-
12 cational expenses, and reasonable living expenses in-
13 curred in the attendance of the school involved; and

14 “(2) may be expended for stipends to eligible
15 individuals for the enrolled period at eligible schools,
16 except that such a stipend may not be provided to
17 an individual for more than 4 years, and such a sti-
18 pend may not exceed \$35,000 per year (notwith-
19 standing any other provision of law regarding the
20 amount of stipends).

21 “(c) DEFINITIONS.—In this section:

22 “(1) ELIGIBLE SCHOOL.—The term ‘eligible
23 school’ means a school of medicine, osteopathic med-
24 icine, dentistry, nursing (as defined in section 801),
25 pharmacy, podiatric medicine, optometry, veterinary
26 medicine, public health, chiropractic, or allied health,



1 a school offering a graduate program in mental and
2 behavioral health practice, or an entity providing
3 programs for the training of physician assistants.

4 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
5 individual’ means an individual who has obtained a
6 secondary school diploma or its recognized equiva-
7 lent.

8 “(d) PRIORITY.—In providing scholarships to eligible
9 individuals, eligible schools shall give to individuals from
10 disadvantaged backgrounds.

11 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section,
13 such sums as may be necessary for each of fiscal years
14 2007 through 2012.”.

15 **SEC. 310. STRENGTHENING AND EXPANDING RURAL**
16 **HEALTH PROVIDER NETWORKS.**

17 Section 330A of the Public Health Service Act (42
18 U.S.C. 254e) is amended—

19 (1) in subsection (h), by adding at the end the
20 following:

21 “(4) RURAL MINORITY, BORDER, AND INDIAN
22 POPULATIONS.—In making grants under this sec-
23 tion, the Director of the Office of Rural Health Pol-
24 icy of the Health Resources and Services Adminis-
25 tration, in coordination with the Director of the In-



1 dian Health Service and the Director of the Office
2 of Minority Health, shall make grants to entities
3 that serve rural minority, border, and Indian popu-
4 lations.

5 “(5) DIVERSITY HEALTH TRAINING PRO-
6 GRAMS.—The Director of the Office of Rural Health
7 Policy of the Health Resources and Services Admin-
8 istration, in coordination with the Director of the In-
9 dian Health Service and the Director of the Office
10 of Minority Health, shall coordinate the awarding of
11 grants under this section with the awarding of
12 grants and contracts under section 765 to connect
13 and integrate diversity health training programs.”;
14 and

15 (2) in subsection (k), as redesignated by this
16 section, by striking “and such sums as may be nec-
17 essary for each of fiscal years 2003 through 2006”
18 and inserting “, such sums as may be necessary for
19 each of fiscal years 2003 through 2005, and
20 \$60,000,000 for each of fiscal years 2006 through
21 2010”.



1 **SEC. 311. NATIONAL REPORT ON THE PREPAREDNESS OF**
2 **HEALTH PROFESSIONALS TO CARE FOR DI-**
3 **VERSE POPULATIONS.**

4 The Secretary of Health and Human Services shall
5 include in the report prepared under section 1707(c) of
6 the Public Health Service Act (as added by section 603
7 of this Act), information relating to the preparedness of
8 health professionals to care for racially and ethnically di-
9 verse populations. Such information, which shall be col-
10 lected by the Bureau of Health Professions, shall
11 include—

12 (1) with respect to health professions education,
13 the number and percentage of hours of classroom
14 discussion relating to minority health issues, includ-
15 ing cultural competence;

16 (2) a description of the coursework involved in
17 such education;

18 (3) a description of the results of an evaluation
19 of the preparedness of students in such education;

20 (4) a description of the types of exposure that
21 students have during their education to minority pa-
22 tient populations; and

23 (5) a description of model programs and prac-
24 tices.



1 **SEC. 312. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

2 Subtitle A–1 of title XXIX of the Public Health Serv-
3 ice Act, as amended by section 301, is further amended
4 by adding at the end the following:

5 **“SEC. 2920B. DAVID SATCHER PUBLIC HEALTH AND**
6 **HEALTH SERVICES CORPS.**

7 “(a) IN GENERAL.—The Administrator of the Health
8 Resources and Services Administration and Director of
9 the Centers for Disease Control and Prevention, in col-
10 laboration with the Director of the Office of Minority
11 Health, shall award grants to eligible entities to increase
12 awareness among post-primary and post-secondary stu-
13 dents of career opportunities in the health professions.

14 “(b) ELIGIBILITY.—To be eligible to receive a grant
15 under subsection (a) an entity shall—

16 “(1) be a clinical, public health or health serv-
17 ices organization, community-based or non-profit en-
18 tity, or other entity determined appropriate by the
19 Director of the Centers for Disease Control and Pre-
20 vention;

21 “(2) serve a health professional shortage area,
22 as determined by the Secretary;

23 “(3) work with students, including those from
24 racial and ethnic minority backgrounds, that have
25 expressed an interest in the health professions; and



1 “(4) submit to the Secretary an application at
2 such time, in such manner, and containing such in-
3 formation as the Secretary may require.

4 “(c) USE OF FUNDS.—Grant awards under sub-
5 section (a) shall be used to support internships that will
6 increase awareness among students of non-research based
7 and career opportunities in the following health profes-
8 sions:

9 “(1) Medicine.

10 “(2) Nursing.

11 “(3) Public Health.

12 “(4) Pharmacy.

13 “(5) Health Administration and Management.

14 “(6) Health Policy.

15 “(7) Psychology.

16 “(8) Dentistry.

17 “(9) International Health.

18 “(10) Social Work.

19 “(11) Allied Health.

20 “(12) Other professions deemed appropriate by
21 the Director of the Centers for Disease Control and
22 Prevention.

23 “(d) PRIORITY.—In awarding grants under sub-
24 section (a), the Director of the Centers for Disease Con-



1 trol and Prevention shall give priority to those entities
2 that—

3 “(1) serve a high proportion of individuals from
4 disadvantaged backgrounds;

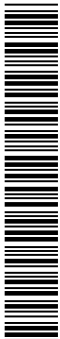
5 “(2) have experience in health disparity elimi-
6 nation programs;

7 “(3) facilitate the entry of disadvantaged indi-
8 viduals into institutions of higher education; and

9 “(4) provide counseling or other services de-
10 signed to assist disadvantaged individuals in success-
11 fully completing their education at the post-sec-
12 ondary level.

13 “(f) STIPENDS.—The Secretary may approve sti-
14 pends under this section for individuals for any period of
15 education in student-enhancement programs (other than
16 regular courses) at health professions schools, programs,
17 or entities, except that such a stipend may not be provided
18 to an individual for more than 6 months, and such a sti-
19 pend may not exceed \$20 per day (notwithstanding any
20 other provision of law regarding the amount of stipends).

21 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section,
23 such sums as may be necessary for each of fiscal years
24 2007 through 2012.



1 **“SEC. 2920C. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
2 **PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Centers for
4 Disease Control and Prevention, in collaboration with the
5 Director of the Office of Minority Health, shall award
6 scholarships to postsecondary students who seek a career
7 in public health.

8 “(b) ELIGIBILITY.—To be eligible to receive a schol-
9 arship under subsection (a) an individual shall—

10 “(1) have experience in public health research
11 or public health practice, or other health professions
12 as determined appropriate by the Director of the
13 Centers for Disease Control and Prevention;

14 “(2) reside in a health professional shortage
15 area as determined by the Secretary;

16 “(3) have expressed an interest in public health;

17 “(4) demonstrate promise for becoming a leader
18 in public health;

19 “(5) secure admission to a 4-year institution of
20 higher education;

21 “(6) comply with subsection (f); and

22 “(7) submit to the Secretary an application at
23 such time, in such manner, and containing such in-
24 formation as the Secretary may require.



1 “(c) USE OF FUNDS.—Amounts received under an
2 award under subsection (a) shall be used to support oppor-
3 tunities for students to become public health professionals.

4 “(d) PRIORITY.—In awarding grants under sub-
5 section (a), the Director shall give priority to those stu-
6 dents that—

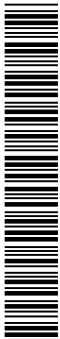
7 “(1) are from disadvantaged backgrounds;

8 “(2) have secured admissions to a minority
9 serving institution; and

10 “(3) have identified a health professional as a
11 mentor at their school or institution and an aca-
12 demic advisor to assist in the completion of their
13 baccalaureate degree.

14 “(e) SCHOLARSHIPS.—The Secretary may approve
15 payment of scholarships under this section for such indi-
16 viduals for any period of education in student under-
17 graduate tenure, except that such a scholarship may not
18 be provided to an individual for more than 4 years, and
19 such scholarships may not exceed \$10,000 per academic
20 year (notwithstanding any other provision of law regard-
21 ing the amount of scholarship).

22 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
23 is authorized to be appropriated to carry out this section,
24 such sums as may be necessary for each of fiscal years
25 2007 through 2012.



1 **“SEC. 2920D. PATSY MINK HEALTH AND GENDER RESEARCH**
2 **FELLOWSHIP PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Centers for
4 Disease Control and Prevention, in collaboration with the
5 Director of the Office of Minority Health, the Adminis-
6 trator of the Substance Abuse and Mental Health Services
7 Administration, and the Director of the Indian Health
8 Services, shall award research fellowships to post-bacca-
9 laureate students to conduct research that will examine
10 gender and health disparities and to pursue a career in
11 the health professions.

12 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
13 ship under subsection (a) an individual shall—

14 “(1) have experience in health research or pub-
15 lic health practice;

16 “(2) reside in a health professional shortage
17 area as determined by the Secretary;

18 “(3) have expressed an interest in the health
19 professions;

20 “(4) demonstrate promise for becoming a leader
21 in the field of women’s health;

22 “(5) secure admission to a health professions
23 school or graduate program with an emphasis in
24 gender studies;

25 “(6) comply with subsection (f); and



1 “(7) submit to the Secretary an application at
2 such time, in such manner, and containing such in-
3 formation as the Secretary may require.

4 “(c) USE OF FUNDS.—Amounts received under an
5 award under subsection (a) shall be used to support oppor-
6 tunities for students to become researchers and advance
7 the research base on the intersection between gender and
8 health.

9 “(d) PRIORITY.—In awarding grants under sub-
10 section (a), the Director of the Centers for Disease Con-
11 trol and Prevention shall give priority to those applicants
12 that—

13 “(1) are from disadvantaged backgrounds; and

14 “(2) have identified a mentor and academic ad-
15 visor who will assist in the completion of their grad-
16 uate or professional degree and have secured a re-
17 search assistant position with a researcher working
18 in the area of gender and health.

19 “(e) FELLOWSHIPS.—The Director of the Centers for
20 Disease Control and Prevention may approve fellowships
21 for individuals under this section for any period of edu-
22 cation in the student’s graduate or health profession ten-
23 ure, except that such a fellowship may not be provided
24 to an individual for more than 3 years, and such a fellow-
25 ship may not exceed \$18,000 per academic year (notwith-



1 standing any other provision of law regarding the amount
2 of fellowship).

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2007 through 2012.

7 **“SEC. 2920E. PAUL DAVID WELLSTONE INTERNATIONAL**
8 **HEALTH FELLOWSHIP PROGRAM.**

9 “(a) IN GENERAL.—The Director of the Agency for
10 Healthcare Research and Quality, in collaboration with
11 the Director of the Office of Minority Health, shall award
12 research fellowships to college students or recent grad-
13 uates to advance their understanding of international
14 health.

15 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
16 ship under subsection (a) an individual shall—

17 “(1) have educational experience in the field of
18 international health;

19 “(2) reside in a health professional shortage
20 area as determined by the Secretary;

21 “(3) demonstrate promise for becoming a leader
22 in the field of international health;

23 “(4) be a college senior or recent graduate of
24 a four year higher education institution;

25 “(5) comply with subsection (f); and



1 “(6) submit to the Secretary an application at
2 such time, in such manner, and containing such in-
3 formation as the Secretary may require.

4 “(c) USE OF FUNDS.—Amounts received under an
5 award under subsection (a) shall be used to support oppor-
6 tunities for students to become health professionals and
7 to advance their knowledge about international issues re-
8 lating to healthcare access and quality.

9 “(d) PRIORITY.—In awarding grants under sub-
10 section (a), the Director shall give priority to those appli-
11 cants that—

12 “(1) are from a disadvantaged background; and

13 “(2) have identified a mentor at a health pro-
14 fessions school or institution, an academic advisor to
15 assist in the completion of their graduate or profes-
16 sional degree, and an advisor from an international
17 health Non-Governmental Organization, Private Vol-
18 unteer Organization, or other international institu-
19 tion or program that focuses on increasing
20 healthcare access and quality for residents in devel-
21 oping countries.

22 “(e) FELLOWSHIPS.—The Secretary shall approve
23 fellowships for college seniors or recent graduates, except
24 that such a fellowship may not be provided to an indi-
25 vidual for more than 6 months, may not be awarded to



1 a graduate that has not been enrolled in school for more
2 than 1 year, and may not exceed \$4,000 per academic year
3 (notwithstanding any other provision of law regarding the
4 amount of fellowship).

5 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 is authorized to be appropriated to carry out this section,
7 such sums as may be necessary for each of fiscal years
8 2007 through 2012.

9 **“SEC. 2920F. EDWARD R. ROYBAL HEALTHCARE SCHOLAR**
10 **PROGRAM.**

11 “(a) IN GENERAL.—The Director of the Agency for
12 Healthcare Research and Quality, the Director of the Cen-
13 ters for Medicaid and Medicare, and the Administrator for
14 Health Resources and Services Administration, in collabo-
15 ration with the Director of the Office of Minority Health,
16 shall award grants to eligible entities to expose entering
17 graduate students to the health professions.

18 “(b) ELIGIBILITY.—To be eligible to receive a grant
19 under subsection (a) an entity shall—

20 “(1) be a clinical, public health or health serv-
21 ices organization, community-based or non-profit en-
22 tity, or other entity determined appropriate by the
23 Director of the Agency for Healthcare Research and
24 Quality;



1 “(2) serve in a health professional shortage
2 area as determined by the Secretary;

3 “(3) work with students obtaining a degree in
4 the health professions; and

5 “(4) submit to the Secretary an application at
6 such time, in such manner, and containing such in-
7 formation as the Secretary may require.

8 “(c) USE OF FUNDS.—Amounts received under a
9 grant awarded under subsection (a) shall be used to sup-
10 port opportunities that expose students to non-research
11 based health professions, including—

12 “(1) public health policy;

13 “(2) healthcare and pharmaceutical policy;

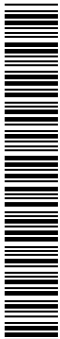
14 “(3) healthcare administration and manage-
15 ment;

16 “(4) health economics; and

17 “(5) other professions determined appropriate
18 by the Director of the Agency for Healthcare Re-
19 search and Quality.

20 “(d) PRIORITY.—In awarding grants under sub-
21 section (a), the Director of the Agency for Healthcare Re-
22 search and Quality shall give priority to those entities
23 that—

24 “(1) have experience with health disparity elimi-
25 nation programs;



1 “(2) facilitate training in the fields described in
2 subsection (c); and

3 “(3) provide counseling or other services de-
4 signed to assist such individuals in successfully com-
5 pleting their education at the post-secondary level.

6 “(e) STIPENDS.—The Secretary may approve the
7 payment of stipends for individuals under this section for
8 any period of education in student-enhancement programs
9 (other than regular courses) at health professions schools
10 or entities, except that such a stipend may not be provided
11 to an individual for more than 2 months, and such a sti-
12 pend may not exceed \$100 per day (notwithstanding any
13 other provision of law regarding the amount of stipends).

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2007 through 2012.”.

18 **SEC. 313. ADVISORY COMMITTEE ON HEALTH PROFES-**
19 **SIONS TRAINING FOR DIVERSITY.**

20 (a) ESTABLISHMENT.—The Secretary of Health and
21 Human Services (referred to in this section as the “Sec-
22 retary”) shall establish an advisory committee to be known
23 as the Advisory Committee on Health Professions Train-
24 ing for Diversity (in this section referred to as the “Advi-
25 sory Committee”).



1 (b) COMPOSITION.—

2 (1) IN GENERAL.—The Secretary shall deter-
3 mine the appropriate number of individuals to serve
4 on the Advisory Committee. Such individuals shall
5 not be officers or employees of the Federal Govern-
6 ment.

7 (2) APPOINTMENT.—Not later than 60 days
8 after the date of enactment of this section, the Sec-
9 retary shall appoint the members of the Advisory
10 Committee from among individuals who are health
11 professionals. In making such appointments, the
12 Secretary shall ensure a fair balance between the
13 health professions, that at least 75 percent of the
14 members of the Advisory Committee are health pro-
15 fessionals, a broad geographic representation of
16 members and a balance between urban and rural
17 members. Members shall be appointed based on their
18 competence, interest, and knowledge of the mission
19 of the profession involved.

20 (3) MINORITY REPRESENTATION.—In appoint-
21 ing the members of the Advisory Committee under
22 paragraph (2), the Secretary shall ensure the ade-
23 quate representation of women and minorities.

24 (c) TERMS.—



1 (1) IN GENERAL.—A member of the Advisory
2 Committee shall be appointed for a term of 3 years,
3 except that of the members first appointed—

4 (A) 1/3 of such members shall serve for a
5 term of 1 year;

6 (B) 1/3 of such members shall serve for a
7 term of 2 years; and

8 (C) 1/3 of such members shall serve for a
9 term of 3 years.

10 (2) VACANCIES.—

11 (A) IN GENERAL.—A vacancy on the Advi-
12 sory Committee shall be filled in the manner in
13 which the original appointment was made and
14 shall be subject to any conditions which applied
15 with respect to the original appointment.

16 (B) FILLING UNEXPIRED TERM.—An indi-
17 vidual chosen to fill a vacancy shall be ap-
18 pointed for the unexpired term of the member
19 replaced.

20 (d) DUTIES.—

21 (1) IN GENERAL.—The Advisory Committee
22 shall—

23 (A) provide advice and recommendations to
24 the Secretary concerning policy and program



1 development and other matters of significance
2 concerning activities under this part; and

3 (B) not later than 2 years after the date
4 of enactment of this section, and annually
5 thereafter, prepare and submit to the Secretary,
6 and the Committee on Health, Education,
7 Labor and Pensions of the Senate, and the
8 Committee on Energy and Commerce of the
9 House of Representatives, a report describing
10 the activities of the Committee.

11 (2) CONSULTATION WITH STUDENTS.—In car-
12 rying out duties under paragraph (1), the Advisory
13 Committee shall consult with individuals who are at-
14 tending health professions schools with which this
15 part is concerned.

16 (e) MEETINGS AND DOCUMENTS.—

17 (1) MEETINGS.—The Advisory Committee shall
18 meet not less than 2 times each year. Such meetings
19 shall be held jointly with other related entities estab-
20 lished under this title where appropriate.

21 (2) DOCUMENTS.—Not later than 14 days prior
22 to the convening of a meeting under paragraph (1),
23 the Advisory Committee shall prepare and make
24 available an agenda of the matters to be considered
25 by the Advisory Committee at such meeting. At any



1 such meeting, the Advisory Committee shall dis-
2 tribute materials with respect to the issues to be ad-
3 dressed at the meeting. Not later than 30 days after
4 the adjourning of such a meeting, the Advisory Com-
5 mittee shall prepare and make available a summary
6 of the meeting and any actions taken by the Com-
7 mittee based upon the meeting.

8 (f) COMPENSATION AND EXPENSES.—

9 (1) COMPENSATION.—Each member of the Ad-
10 visory Committee shall be compensated at a rate
11 equal to the daily equivalent of the annual rate of
12 basic pay prescribed for level IV of the Executive
13 Schedule under section 5315 of title 5, United
14 States Code, for each day (including travel time)
15 during which such member is engaged in the per-
16 formance of the duties of the Committee.

17 (2) EXPENSES.—The members of the Advisory
18 Committee shall be allowed travel expenses, includ-
19 ing per diem in lieu of subsistence, at rates author-
20 ized for employees of agencies under subchapter I of
21 chapter 57 of title 5, United States Code, while
22 away from their homes or regular places of business
23 in the performance of services for the Committee.

24 (g) FACA.—The Federal Advisory Committee Act
25 shall apply to the Advisory Committee under this section



1 only to the extent that the provisions of such Act do not
2 conflict with the requirements of this section.

3 **SEC. 314. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
4 **PROGRAM.**

5 Section 402E of the Higher Education Act of 1965
6 (20 U.S.C. 1070a-15) is amended by striking subsection
7 (f) and inserting the following:

8 “(f) COLLABORATION IN HEALTH PROFESSION DI-
9 VERSITY TRAINING PROGRAMS.—The Secretary of Edu-
10 cation shall coordinate with the Secretary of Health and
11 Human Services to ensure that there is collaboration be-
12 tween the goals of the program under this section and pro-
13 grams of the Health Resources and Services Administra-
14 tion that promote health workforce diversity. The Sec-
15 retary of Education shall take such measures as may be
16 necessary to encourage participants in programs under
17 this section to consider health profession careers.

18 “(g) FUNDING.—From amounts appropriated pursu-
19 ant to the authority of section 402A(f), the Secretary
20 shall, to the extent practicable, allocate funds for projects
21 authorized by this section in an amount which is not less
22 than \$31,000,000 for each of the fiscal years 2006
23 through 2012.”.



1 **TITLE IV—REDUCING DISEASE**
2 **AND DISEASE-RELATED COM-**
3 **PLICATIONS**

4 **Subtitle A—Education and**
5 **Outreach**

6 **SEC. 401. PREVENTIVE HEALTH SERVICES BLOCK GRANTS;**
7 **USE OF ALLOTMENTS.**

8 Section 1904(a)(1) of the Public Health Service Act
9 (42 U.S.C. 300w–3(a)(1)) is amended—

10 (1) in subparagraph (G)—

11 (A) by striking “through (F)” and insert-
12 ing “through (G)”; and

13 (B) by redesignating such subparagraph as
14 subparagraph (H); and

15 (2) by inserting after subparagraph (F), the fol-
16 lowing:

17 “(G) Community outreach and education pro-
18 grams and other activities designed to address and
19 prevent minority health conditions (as defined in
20 section 485E(c)(2)).”.

21 **SEC. 402. INDIGENOUS, RACIAL AND ETHNIC APPROACHES**
22 **TO COMMUNITY HEALTH.**

23 (a) PURPOSE.—It is the purpose of this section to
24 provide for the awarding of grants to assist communities
25 in mobilizing and organizing resources in support of effec-



1 tive and sustainable programs that will reduce or eliminate
2 disparities in health and healthcare experienced by racial
3 and ethnic minority individuals.

4 (b) AUTHORITY TO AWARD GRANTS.—The Secretary,
5 acting through the Centers for Disease Control and Pre-
6 vention and the Office of Minority Health, shall award
7 planning, implementation, and evaluation grants to eligi-
8 ble entities to assist in designing, implementing, and eval-
9 uating culturally and linguistically appropriate, science-
10 based, and community-driven strategies to eliminate racial
11 and ethnic health and healthcare disparities.

12 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
13 grant under this section, an entity shall—

14 (1) represent a coalition—

15 (A) whose principal purpose is to develop
16 and implement interventions to reduce or elimi-
17 nate a health or healthcare disparity in a tar-
18 geted racial or ethnic minority group in the
19 community served by the coalition; and

20 (B) that includes—

21 (i) at least 3 members selected from
22 among—

23 (I) public health departments;

24 (II) community-based organiza-
25 tions;



1 (III) university and/or research
2 organizations;

3 (IV) Indian tribal organizations
4 or national Indian organizations;

5 (V) Native Hawaiian organiza-
6 tions (defined for purposes of this
7 subclause as an organization that
8 serves and represents the interests of
9 Native Hawaiians and has as a pri-
10 mary and stated purpose the provision
11 of services to Native Hawaiians); and

12 (VI) interested public or private
13 sector healthcare providers or organi-
14 zations;

15 (ii) at least 1 member that is from a
16 community-based organization that rep-
17 resents the targeted racial or ethnic minor-
18 ity group; and

19 (iii) at least 1 member that is a Na-
20 tional Center for Minority Health and
21 Health Disparities Center of Excellence
22 (unless such a Center does not exist within
23 the community involved, declines or refuses
24 to participate, or the coalition dem-
25 onstrates to the Secretary that such par-



1 ticipation would not further the goals of
2 the program or would be unduly burden-
3 some); and

4 (2) submit to the Secretary an application, at
5 such time, in such manner, and containing such in-
6 formation as the Secretary may require, including—

7 (A) a description of the targeted racial or
8 ethnic population in the community to be served
9 under the grant;

10 (B) a description of at least 1 health dis-
11 parity that exists in the racial or ethnic tar-
12 geted population; and

13 (C) a demonstration of the proven record
14 of accomplishment of the coalition members in
15 serving and working with the targeted commu-
16 nity.

17 (d) PLANNING GRANTS.—

18 (1) IN GENERAL.—The Secretary shall award
19 grants to eligible entities described in subsection (c)
20 to support the planning and development of cul-
21 turally and linguistically appropriate programs that
22 utilize science-based and community-driven strate-
23 gies to reduce or eliminate a health or healthcare
24 disparity in the targeted population. Such grants
25 may be used to—



1 (A) expand the coalition that is rep-
2 resented by the entity through the identification
3 of additional partners, particularly among the
4 targeted community, and establish linkages with
5 national and State public and private partners;

6 (B) establish community working groups;

7 (C) conduct a needs assessment for the
8 targeted population in the area of the health
9 disparity using input from the targeted commu-
10 nity;

11 (D) participate in workshops sponsored by
12 the Office of Minority Health or the Centers for
13 Disease Control and Prevention for technical
14 assistance, planning, evaluation, and other pro-
15 grammatic issues;

16 (E) identify promising intervention strate-
17 gies; and

18 (F) develop a plan with the input of the
19 targeted community that includes strategies
20 for—

21 (i) implementing intervention strate-
22 gies that have the most promising potential
23 for reducing the health disparity in the
24 target population;



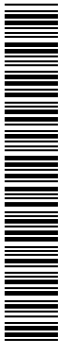
1 (ii) identifying other sources of rev-
2 enue and integrating current and proposed
3 funding sources to ensure long-term sus-
4 tainability of the program; and

5 (iii) evaluating the program, including
6 collecting data and measuring progress to-
7 ward reducing or eliminating the health
8 disparity in the targeted population that
9 takes into account the evaluation model de-
10 veloped by the Centers for Disease Control
11 and Prevention in collaboration with the
12 Office of Minority Health.

13 (2) DURATION.—The period during which pay-
14 ments may be made under a grant under paragraph
15 (1) shall not exceed 1 year, except where the Sec-
16 retary determines that extraordinary circumstances
17 exist as described in section 340(c)(3) of the Public
18 Health Service Act.

19 (e) IMPLEMENTATION GRANTS.—

20 (1) IN GENERAL.—The Secretary shall award
21 grants to eligible entities that have received a plan-
22 ning grant under subsection (d) to enable such enti-
23 ty to—



1 (A) implement a plan to address the se-
2 lected health disparity for the target population,
3 in an effective and timely manner;

4 (B) collect data appropriate for monitoring
5 and evaluating the program carried out under
6 the grant;

7 (C) analyze and interpret data, or collabo-
8 rate with academic or other appropriate institu-
9 tions, for such analysis and collection;

10 (D) participate in conferences and work-
11 shops for the purpose of informing and edu-
12 cating others regarding the experiences and les-
13 sons learned from the project;

14 (E) collaborate with appropriate partners
15 to publish the results of the project for the ben-
16 efit of the public health community;

17 (F) establish mechanisms with other public
18 or private groups to maintain financial support
19 for the program after the grant terminates; and

20 (G) maintain relationships with local part-
21 ners and continue to develop new relationships
22 with State and national partners.

23 (2) DURATION.—The period during which pay-
24 ments may be made under a grant under paragraph
25 (1) shall not exceed 4 years. Such payments shall be



1 subject to annual approval by the Secretary and to
2 the availability of appropriations for the fiscal year
3 involved.

4 (f) EVALUATION GRANTS.—

5 (1) IN GENERAL.—The Secretary shall award
6 grants to eligible entities that have received an im-
7 plementation grant under subsection (e) that require
8 additional assistance for the purpose of rigorous
9 data analysis, program evaluation (including process
10 and outcome measures), or dissemination of find-
11 ings.

12 (2) PRIORITY.—In awarding grants under this
13 subsection, the Secretary shall give priority to—

14 (A) entities that in previous funding
15 cycles—

16 (i) have received a planning grant
17 under subsection (d); and

18 (ii) implemented activities of the type
19 described in subsection (e)(1);

20 (B) entities that fulfilled the goals of their
21 planning grant under subsection (d) in an espe-
22 cially timely manner;

23 (C) entities that incorporate best practices
24 or build on successful models in their action



1 plan, including the use of community health
2 workers; and

3 (D) entities that would enable the Sec-
4 retary to provide for an equitable distribution of
5 such grants among the 5 categories for race
6 and ethnicity described in the 1997 Office of
7 Management and Budget Standards for Main-
8 taining, Collecting, and Presenting Federal
9 Data on Race and Ethnicity.

10 (g) MAINTENANCE OF EFFORT.—The Secretary may
11 not award a grant to an eligible entity under this section
12 unless the entity agrees that, with respect to the costs to
13 be incurred by the entity in carrying out the activities for
14 which the grant was awarded, the entity (and each of the
15 participating partners in the coalition represented by the
16 entity) will maintain its expenditures of non-Federal funds
17 for such activities at a level that is not less than the level
18 of such expenditures during the fiscal year immediately
19 preceding the first fiscal year for which the grant is
20 awarded.

21 (h) TECHNICAL ASSISTANCE.—The Secretary may,
22 either directly or by grant or contract, provide any entity
23 that receives a grant under this section with technical and
24 other nonfinancial assistance necessary to meet the re-
25 quirements of this section.



1 (i) ADMINISTRATIVE BURDENS.—The Secretary shall
2 make every effort to minimize duplicative or unnecessary
3 administrative burdens on grantees in the process of ap-
4 plying for grants under subsection (d), (e), or (f).

5 (j) REPORT.—Not later than September 30, 2009,
6 the Secretary shall publish a report that describes the ex-
7 tent to which the activities funded under this section have
8 been successful in reducing and eliminating disparities in
9 health and healthcare in targeted populations, and pro-
10 vides examples of best practices or model programs funded
11 under this section.

12 (k) AUTHORIZATION OF APPROPRIATIONS.—There is
13 authorized to be appropriated such sums as may be nec-
14 essary to carry out this section for each of fiscal years
15 2007 through 2012.

16 **SEC. 403. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**
17 **IORS IN WOMEN.**

18 Part P of title III of the Public Health Service Act
19 (42 U.S.C. 280g et seq.) is amended by adding at the end
20 the following:

21 **“SEC. 3990. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
22 **HAVIORS IN WOMEN.**

23 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
24 laboration with the Director of the Centers for Disease
25 Control and Prevention and other Federal officials deter-



1 mined appropriate by the Secretary, is authorized to
2 award grants to States or local or tribal units, to promote
3 positive health behaviors for women in target populations,
4 especially racial and ethnic minority women in medically
5 underserved communities.

6 “(b) USE OF FUNDS.—Grants awarded pursuant to
7 subsection (a) may be used to support community health
8 workers—

9 “(1) to educate, guide, and provide outreach in
10 a community setting regarding health problems prev-
11 alent among women including racial and ethnic mi-
12 nority women;

13 “(2) to educate, guide, and provide experiential
14 learning opportunities that target behavioral risk
15 factors;

16 “(3) to educate and guide regarding effective
17 strategies to promote positive health behaviors with-
18 in the family;

19 “(4) to educate and provide outreach regarding
20 enrollment in health insurance including the State
21 Children’s Health Insurance Program under title
22 XXI of the Social Security Act, medicare under title
23 XVIII of such Act and medicaid under title XIX of
24 such Act;



1 “(5) to promote community wellness and aware-
2 ness; and

3 “(6) to educate and refer target populations to
4 appropriate health care agencies and community-
5 based programs and organizations in order to in-
6 crease access to quality health care services, includ-
7 ing preventive health services.

8 “(c) APPLICATION.—

9 “(1) IN GENERAL.—Each State or local or trib-
10 al unit (including federally recognized tribes and
11 Alaska native villages) that desires to receive a grant
12 under subsection (a) shall submit an application to
13 the Secretary, at such time, in such manner, and ac-
14 companied by such additional information as the
15 Secretary may require.

16 “(2) CONTENTS.—Each application submitted
17 pursuant to paragraph (1) shall—

18 “(A) describe the activities for which as-
19 sistance under this section is sought;

20 “(B) contain an assurance that with re-
21 spect to each community health worker pro-
22 gram receiving funds under the grant awarded,
23 such program provides training and supervision
24 to community health workers to enable such
25 workers to provide authorized program services;



1 “(C) contain an assurance that the appli-
2 cant will evaluate the effectiveness of commu-
3 nity health worker programs receiving funds
4 under the grant;

5 “(D) contain an assurance that each com-
6 munity health worker program receiving funds
7 under the grant will provide services in the cul-
8 tural context most appropriate for the individ-
9 uals served by the program;

10 “(E) contain a plan to document and dis-
11 seminate project description and results to
12 other States and organizations as identified by
13 the Secretary; and

14 “(F) describe plans to enhance the capac-
15 ity of individuals to utilize health services and
16 health-related social services under Federal,
17 State, and local programs by—

18 “(i) assisting individuals in estab-
19 lishing eligibility under the programs and
20 in receiving the services or other benefits
21 of the programs; and

22 “(ii) providing other services as the
23 Secretary determines to be appropriate,
24 that may include transportation and trans-
25 lation services.



1 “(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Secretary shall give priority to those
3 applicants—

4 “(1) who propose to target geographic areas—

5 “(A) with a high percentage of residents
6 who are eligible for health insurance but are
7 uninsured or underinsured;

8 “(B) with a high percentage of families for
9 whom English is not their primary language;
10 and

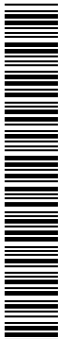
11 “(C) that encompass the United States-
12 Mexico border region;

13 “(2) with experience in providing health or
14 health-related social services to individuals who are
15 underserved with respect to such services; and

16 “(3) with documented community activity and
17 experience with community health workers.

18 “(e) COLLABORATION WITH ACADEMIC INSTITU-
19 TIONS.—The Secretary shall encourage community health
20 worker programs receiving funds under this section to col-
21 laborate with academic institutions. Nothing in this sec-
22 tion shall be construed to require such collaboration.

23 “(f) QUALITY ASSURANCE AND COST-EFFECTIVE-
24 NESS.—The Secretary shall establish guidelines for assur-
25 ing the quality of the training and supervision of commu-



1 nity health workers under the programs funded under this
2 section and for assuring the cost-effectiveness of such pro-
3 grams.

4 “(g) MONITORING.—The Secretary shall monitor
5 community health worker programs identified in approved
6 applications and shall determine whether such programs
7 are in compliance with the guidelines established under
8 subsection (e).

9 “(h) TECHNICAL ASSISTANCE.—The Secretary may
10 provide technical assistance to community health worker
11 programs identified in approved applications with respect
12 to planning, developing, and operating programs under the
13 grant.

14 “(i) REPORT TO CONGRESS.—

15 “(1) IN GENERAL.—Not later than 4 years
16 after the date on which the Secretary first awards
17 grants under subsection (a), the Secretary shall sub-
18 mit to Congress a report regarding the grant
19 project.

20 “(2) CONTENTS.—The report required under
21 paragraph (1) shall include the following:

22 “(A) A description of the programs for
23 which grant funds were used.

24 “(B) The number of individuals served.

25 “(C) An evaluation of—



1 “(i) the effectiveness of these pro-
2 grams;

3 “(ii) the cost of these programs; and

4 “(iii) the impact of the project on the
5 health outcomes of the community resi-
6 dents.

7 “(D) Recommendations for sustaining the
8 community health worker programs developed
9 or assisted under this section.

10 “(E) Recommendations regarding training
11 to enhance career opportunities for community
12 health workers.

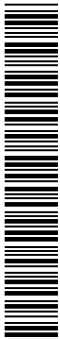
13 “(j) DEFINITIONS.—In this section:

14 “(1) COMMUNITY HEALTH WORKER.—The term
15 ‘community health worker’ means an individual who
16 promotes health or nutrition within the community
17 in which the individual resides—

18 “(A) by serving as a liaison between com-
19 munities and health care agencies;

20 “(B) by providing guidance and social as-
21 sistance to community residents;

22 “(C) by enhancing community residents’
23 ability to effectively communicate with health
24 care providers;



1 “(D) by providing culturally and linguis-
2 tically appropriate health or nutrition edu-
3 cation;

4 “(E) by advocating for individual and com-
5 munity health or nutrition needs; and

6 “(F) by providing referral and follow-up
7 services.

8 “(2) COMMUNITY SETTING.—The term ‘commu-
9 nity setting’ means a home or a community organi-
10 zation located in the neighborhood in which a partic-
11 ipant resides.

12 “(3) MEDICALLY UNDERSERVED COMMUNITY.—
13 The term ‘medically underserved community’ means
14 a community identified by a State—

15 “(A) that has a substantial number of in-
16 dividuals who are members of a medically un-
17 derserved population, as defined by section
18 330(b)(3); and

19 “(B) a significant portion of which is a
20 health professional shortage area as designated
21 under section 332.

22 “(4) SUPPORT.—The term ‘support’ means the
23 provision of training, supervision, and materials
24 needed to effectively deliver the services described in



1 subsection (b), reimbursement for services, and
2 other benefits.

3 “(5) TARGET POPULATION.—The term ‘target
4 population’ means women of reproductive age, re-
5 gardless of their current childbearing status.

6 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section,
8 such sums as may be necessary for each of fiscal years
9 2007 through 2012.”.

10 **SEC. 404. PROVISIONS REGARDING NATIONAL ASTHMA**
11 **EDUCATION AND PREVENTION PROGRAM OF**
12 **NATIONAL HEART, LUNG, AND BLOOD INSTI-**
13 **TUTE.**

14 In addition to any other authorization of appropria-
15 tions that is available to the National Heart, Lung, and
16 Blood Institute for the purpose of carrying out the Na-
17 tional Asthma Education and Prevention Program, there
18 is authorized to be appropriated to such Institute for such
19 purpose such sums as may be necessary for each of fiscal
20 years 2007 through 2012. Amounts appropriated under
21 the preceding sentence shall be expended to expand such
22 Program.



1 **SEC. 405. ASTHMA-RELATED ACTIVITIES OF CENTERS FOR**
2 **DISEASE CONTROL AND PREVENTION.**

3 (a) EXPANSION OF PUBLIC HEALTH SURVEILLANCE
4 ACTIVITIES; PROGRAM FOR PROVIDING INFORMATION
5 AND EDUCATION TO PUBLIC.—The Secretary of Health
6 and Human Services, acting through the Director of the
7 Centers for Disease Control and Prevention, shall collabo-
8 rate with the States to expand the scope of—

9 (1) activities that are carried out to determine
10 the incidence and prevalence of asthma; and

11 (2) activities that are carried out to prevent the
12 health consequences of asthma, including through
13 the provision of information and education to the
14 public regarding asthma, which may include the use
15 of public service announcements through the media
16 and such other means as such Director determines
17 to be appropriate.

18 (b) COMPILATION OF DATA.—The Secretary of
19 Health and Human Services, acting through the Director
20 of the Centers for Disease Control and Prevention and in
21 consultation with the National Asthma Education Preven-
22 tion Program Coordinating Committee, shall—

23 (1) conduct local asthma surveillance activities
24 to collect data on the prevalence and severity of
25 asthma and the quality of asthma management,
26 including—



1 (A) telephone surveys to collect sample
2 household data on the local burden of asthma;
3 and

4 (B) health care facility specific surveillance
5 to collect asthma data on the prevalence and se-
6 verity of asthma, and on the quality of asthma
7 care; and

8 (2) compile and annually publish data on—

9 (A) the prevalence of children suffering
10 from asthma in each State; and

11 (B) the childhood mortality rate associated
12 with asthma nationally and in each State.

13 (c) ADDITIONAL FUNDING.—In addition to any other
14 authorization of appropriations that is available to the
15 Centers for Disease Control and Prevention for the pur-
16 pose of carrying out this section, there is authorized to
17 be appropriated to such Centers for such purpose such
18 sums as may be necessary for each of fiscal years 2007
19 through 2012.

20 **SEC. 406. GRANTS FOR COMMUNITY OUTREACH REGARD-**
21 **ING ASTHMA INFORMATION, EDUCATION,**
22 **AND SERVICES.**

23 (a) IN GENERAL.—The Secretary may make grants
24 to nonprofit private entities for projects to carry out, in
25 communities identified by entities applying for the grants,



1 outreach activities to provide for residents of the commu-
2 nities the following:

3 (1) Information and education on asthma.

4 (2) Referrals to health programs of public and
5 nonprofit private entities that provide asthma-re-
6 lated services, including such services for low-income
7 individuals. The grant may be expended to make ar-
8 rangements to coordinate the activities of such enti-
9 ties in order to establish and operate networks or
10 consortia regarding such referrals.

11 (b) PREFERENCES IN MAKING GRANTS.—In making
12 grants under subsection (a), the Secretary shall give pref-
13 erence to applicants that will carry out projects under such
14 subsection in communities that are disproportionately af-
15 fected by asthma or underserved with respect to the activi-
16 ties described in such subsection and in which a significant
17 number of low-income individuals reside.

18 (c) EVALUATIONS.—A condition for a grant under
19 subsection (a) is that the applicant for the grant agree
20 to provide for the evaluation of the projects carried out
21 under such subsection by the applicant to determine the
22 extent to which the projects have been effective in carrying
23 out the activities referred to in such subsection.

24 (d) FUNDING.—For the purpose of carrying out this
25 section, there is authorized to be appropriated such sums



1 as may be necessary for each of fiscal years 2007 through
2 2012.

3 **SEC. 407. ACTION PLANS OF LOCAL EDUCATIONAL AGEN-**
4 **CIES REGARDING ASTHMA.**

5 (a) IN GENERAL.—

6 (1) SCHOOL-BASED ASTHMA ACTIVITIES.—The
7 Secretary of Education (in this section referred to as
8 the “Secretary”), in consultation with the Director
9 of the Centers for Disease Control and Prevention
10 and the Director of the National Institutes of
11 Health, may make grants to local educational agen-
12 cies for programs to carry out at elementary and
13 secondary schools specified in paragraph (2) asthma-
14 related activities for children who attend such
15 schools.

16 (2) ELIGIBLE SCHOOLS.—The elementary and
17 secondary schools referred to in paragraph (1) are
18 such schools that are located in communities with a
19 significant number of low-income or underserved in-
20 dividuals (as defined by the Secretary).

21 (b) DEVELOPMENT OF PROGRAMS.—Programs under
22 subsection (a) shall include grants under which local edu-
23 cation agencies and State public health officials collabo-
24 rate to develop programs to improve the management of
25 asthma in school settings.



1 (c) CERTAIN GUIDELINES.—Programs under sub-
2 section (a) shall be carried out in accordance with applica-
3 ble guidelines or other recommendations of the National
4 Institutes of Health (including the National Heart, Lung,
5 and Blood Institute) and the Environmental Protection
6 Agency.

7 (d) CERTAIN ACTIVITIES.—Activities that may be
8 carried out in programs under subsection (a) include the
9 following:

10 (1) Identifying and working directly with local
11 hospitals, community clinics, advocacy organizations,
12 parent-teacher associations, minority health organi-
13 zations, and asthma coalitions.

14 (2) Identifying asthmatic children and training
15 them and their families in asthma self-management.

16 (3) Purchasing asthma equipment.

17 (4) Hiring school nurses.

18 (5) Training teachers, nurses, coaches, and
19 other school personnel in asthma-symptom recogni-
20 tion and emergency responses.

21 (6) Simplifying procedures to improve students'
22 safe access to their asthma medications.

23 (7) Such other asthma-related activities as the
24 Secretary determines to be appropriate.



1 (e) DEFINITIONS.—For purposes of this section, the
2 terms “elementary school”, “local educational agency”,
3 and “secondary school” have the meanings given such
4 terms in the Elementary and Secondary Education Act of
5 1965.

6 (f) FUNDING.—For the purpose of carrying out this
7 section, there is authorized to be appropriated such sums
8 as may be necessary for each of fiscal years 2007 through
9 2012.

10 **SEC. 408. PROGRAMS OF CENTERS FOR DISEASE CONTROL**
11 **AND PREVENTION.**

12 Part B of title III of the Public Health Service Act
13 (42 U.S.C. 243 et seq.) is amended by striking section
14 317H and inserting the following:

15 **“SEC. 317H. DIABETES IN CHILDREN AND YOUTH.**

16 “(a) SURVEILLANCE ON TYPE 1 DIABETES.—The
17 Secretary, acting through the Director of the Centers for
18 Disease Control and Prevention and in consultation with
19 the Director of the National Institutes of Health, shall de-
20 velop a sentinel system to collect data on type 1 diabetes,
21 including the incidence and prevalence of type 1 diabetes
22 and shall establish a national database for such data.

23 “(b) TYPE 2 DIABETES IN YOUTH.—The Secretary
24 shall implement a national public health effort to address
25 type 2 diabetes in youth, including—



1 “(1) enhancing surveillance systems and ex-
2 panding research to better assess the prevalence and
3 incidence of type 2 diabetes in youth and determine
4 the extent to which type 2 diabetes is incorrectly di-
5 agnosed as type 1 diabetes among children;

6 “(2) standardizing and improving methods to
7 assist in diagnosis, treatment, and prevention of dia-
8 betes including developing less invasive ways to mon-
9 itor blood glucose to prevent hypoglycemia such as
10 nonmydriatic retinal imaging and improving existing
11 glucometers that measure blood glucose; and

12 “(3) developing methods to identify obstacles
13 facing children in traditionally underserved popu-
14 lations to obtain care to prevent or treat type 2 dia-
15 betes.

16 “(c) LONG-TERM EPIDEMIOLOGICAL STUDIES ON DI-
17 ABETES IN CHILDREN.—The Secretary, acting through
18 the Director of the Centers for Disease Control and Pre-
19 vention and the Director of the National Institute of Dia-
20 betes and Digestive and Kidney Diseases, shall conduct
21 or support long-term epidemiology studies in children with
22 diabetes or at risk for diabetes. Such studies shall inves-
23 tigate the causes and characteristics of the disease and
24 its complications.



1 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section,
3 such sums as may be necessary for each of fiscal years
4 2007 through 2012.”.

5 **SEC. 409. RESEARCH WITH RESPECT TO UTERINE**
6 **FIBROIDS.**

7 (a) IN GENERAL.—The Director of the National In-
8 stitutes of Health (in this section referred to as the “Di-
9 rector of NIH”) shall expand, intensify, and coordinate
10 programs for the conduct and support of research with
11 respect to uterine fibroids.

12 (b) ADMINISTRATION.—

13 (1) IN GENERAL.—The Director of NIH shall
14 carry out this section through the appropriate insti-
15 tutes, offices, and centers, including the National In-
16 stitute of Child Health and Human Development,
17 the National Institute of Environmental Health
18 Sciences, the Office of Research on Women’s Health,
19 the National Center on Minority Health and Health
20 Disparities, and any other agencies that the Director
21 of NIH determines to be appropriate.

22 (2) COORDINATION OF ACTIVITIES.—The Office
23 of Research on Women’s Health shall coordinate ac-
24 tivities under paragraph (1) among the institutes,



1 offices, and centers of the National Institutes of
2 Health.

3 (c) AUTHORIZATION OF APPROPRIATIONS.—For the
4 purpose of carrying out this section, there are authorized
5 to be appropriated such sums as may be necessary for
6 each of the fiscal years 2007 through 2012.

7 **SEC. 410. INFORMATION AND EDUCATION WITH RESPECT**
8 **TO UTERINE FIBROIDS.**

9 (a) UTERINE FIBROIDS PUBLIC EDUCATION PRO-
10 GRAM.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services (referred to in this section as the
13 “Secretary”), acting through the Director of the
14 Centers for Disease Control and Prevention, shall
15 develop and disseminate to the public information
16 regarding uterine fibroids, including information
17 on—

18 (A) the incidence and prevalence of uterine
19 fibroids;

20 (B) the elevated risk for minority women;
21 and

22 (C) the availability, as medically appro-
23 priate, of a range of treatment options for
24 symptomatic uterine fibroids.



1 (2) DISSEMINATION.—The Secretary may dis-
2 seminate information under paragraph (1) directly,
3 or through arrangements with nonprofit organiza-
4 tions, consumer groups, institutions of higher edu-
5 cation (as defined in section 101 of the Higher Edu-
6 cation Act of 1965 (20 U.S.C. 1001)), Federal,
7 State, or local agencies, or the media.

8 (3) AUTHORIZATION OF APPROPRIATIONS.—For
9 the purpose of carrying out this subsection, there
10 are authorized to be appropriated such sums as may
11 be necessary for each of the fiscal years 2007
12 through 2012.

13 (b) UTERINE FIBROIDS INFORMATION PROGRAM FOR
14 HEALTH CARE PROVIDERS.—

15 (1) IN GENERAL.—The Secretary, acting
16 through the Administrator of the Health Resources
17 and Services Administration, shall develop and dis-
18 seminate to health care providers information on
19 uterine fibroids, including information on the ele-
20 vated risk for minority women and the range of
21 available options for the treatment of symptomatic
22 uterine fibroids.

23 (2) AUTHORIZATION OF APPROPRIATIONS.—For
24 the purpose of carrying out this subsection, there
25 are authorized to be appropriated such sums as may



1 be necessary for each of the fiscal years 2007
2 through 2012.

3 (c) DEFINITION.—For purposes of this section, the
4 term “minority”, with respect to women, means women
5 who are members of racial or ethnic minority groups with-
6 in the meaning of section 1707 of the Public Health Serv-
7 ice Act (42 U.S.C. 300u–6).

8 **Subtitle B—Research and Training**

9 **SEC. 431. INNOVATIVE CHRONIC DISEASE MANAGEMENT** 10 **PROGRAMS.**

11 (a) IN GENERAL.—The Secretary, acting in coordina-
12 tion with the Administrator of the Centers for Medicare
13 and Medicaid Services, the Administrator of the Health
14 Resources and Services Administration, the Director of
15 the National Institutes of Health, the Director of the Cen-
16 ters for Disease Control and Prevention, and the Director
17 of the Office of Minority Health, shall award grants to
18 eligible entities for the identification, implementation, and
19 evaluation of programs for patients with chronic disease.

20 (b) ELIGIBILITY.—To be eligible to receive a grant
21 under subsection (a), an entity shall—

22 (1) be a health center or clinic, public health
23 department, health plan, hospital, health system,
24 community-based or non-profit organization, or



1 other health entity determined appropriate by the
2 Secretary; and

3 (2) prepare and submit to the Secretary an ap-
4 plication at such time, in such manner, and con-
5 taining such information as the Secretary may re-
6 quire.

7 (c) USE OF FUNDS.—An entity shall use amounts re-
8 ceived under a grant under subsection (a) to identify, im-
9 plement, and evaluate chronic disease management pro-
10 grams that are tailored for racially and ethnically diverse
11 populations. In carrying out such activities, an entity shall
12 focus on—

13 (1) self-management training;

14 (2) patient empowerment;

15 (3) group visits;

16 (4) community health workers;

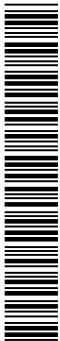
17 (5) case management;

18 (6) work- and school-based interventions;

19 (7) home visitation; or

20 (8) other activities determined appropriate by
21 the Secretary.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section,
24 such sums as may be necessary for each of fiscal years
25 2007 through 2012.



1 **SEC. 432. RESEARCH FUNDING FOR AUTOIMMUNE DISEASE**
2 **IN MINORITY POPULATIONS.**

3 Part B of title IV of the Public Health Service Act
4 is amended by inserting after section 409E (42 U.S.C.
5 284i) the following:

6 **“SEC. 490E-1. RESEARCH FUNDING FOR AUTOIMMUNE DIS-**
7 **EASE IN MINORITY POPULATIONS.**

8 “(a) EXPANSION AND INTENSIFICATION OF ACTIVI-
9 TIES REGARDING AUTOIMMUNE DISEASES ON MINORI-
10 TIES.—With respect to the plan under section 409E(c)(1),
11 the Coordinating Committee shall ensure that provisions
12 of the plan developed under paragraph (2) of such sub-
13 section include provisions for the following:

14 “(1)(A) Basic research, epidemiological re-
15 search, and other appropriate research concerning
16 the etiology and causes of autoimmune diseases in
17 all minorities, including genetic, hormonal, and envi-
18 ronmental factors.

19 “(B)(i) Giving priority under subparagraph (A)
20 to research regarding environmental factors.

21 “(ii) The coordination of (to the extent prac-
22 ticable and appropriate), and providing additional
23 support for, research described in clause (i) that is
24 conducted by public or nonprofit private entities.

25 “(2)(A) The development of information and
26 education programs for patients, healthcare pro-



1 viders, and others as appropriate on genetic, hor-
2 monal, and environmental risk factors associated
3 with autoimmune diseases in minorities, and on the
4 importance of the prevention or control of such risk
5 factors and timely referral with appropriate diag-
6 nosis and treatment.

7 “(B) The inclusion in programs under subpara-
8 graph (A) of information and education on the prev-
9 alence and nature of autoimmune diseases, on risk
10 factors, and on health-related behaviors that can im-
11 prove health status in minority populations.

12 “(3) Outreach programs for purposes of para-
13 graphs (1) and (2) that—

14 “(A) are directed toward minority individ-
15 uals, particularly those who are at-risk for auto-
16 immune diseases; and

17 “(B) are carried out through community
18 health centers, community clinics, or other
19 health centers under section 330, through
20 State, territory, or local health departments, In-
21 dian tribes, or through primary care physicians.

22 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
23 is authorized to be appropriated to carry out this section,
24 such sums as may be necessary for each of fiscal years
25 2007 through 2012.”.



1 **SEC. 433. RESEARCH ON EFFECTIVE MESSAGES FOR COM-**
2 **BATTING STIGMA.**

3 (a) RESEARCH.—The Administrator of the Substance
4 Abuse and Mental Health Services Administration (in this
5 section referred to as the “Administrator”) , in collabora-
6 tion with the Director of the National Institute of Mental
7 Health, shall conduct research to determine—

8 (1) the most effective messages for combating
9 stigma in communities of color; and

10 (2) the most effective media through which to
11 convey those messages.

12 (b) MEDIA.—In making a determination under sub-
13 section (a)(2), the Administrator shall consider a diverse
14 selection of media, including—

15 (1) newspapers;

16 (2) radio and television stations, including sta-
17 tions in languages other than English;

18 (3) posters or pamphlets in community health
19 centers, emergency rooms, and primary health care
20 settings; and

21 (4) outreach in schools.



1 **Subtitle C—Innovative Treatment**
2 **Modalities and Services Deliv-**
3 **ery Models**

4 **SEC. 441. GUIDELINES FOR DISEASE SCREENING FOR MI-**
5 **NORITY PATIENTS.**

6 (a) IN GENERAL.—The Secretary, acting through the
7 Director of the Agency for Healthcare Research and Qual-
8 ity, shall convene a series of meetings to develop guidelines
9 for disease screening for minority patient populations
10 which have a higher than average risk for many chronic
11 diseases and cancers.

12 (b) PARTICIPANTS.—In convening meetings under
13 subsection (a), the Secretary shall ensure that meeting
14 participants include representatives of—

- 15 (1) professional societies and associations;
16 (2) minority health organizations;
17 (3) healthcare researchers and providers, in-
18 cluding those with expertise in minority health;
19 (4) Federal health agencies, including the Of-
20 fice of Minority Health and the National Institutes
21 of Health; and
22 (5) other experts determined appropriate by the
23 Secretary.

24 (c) DISEASES.—Screening guidelines for minority
25 populations shall be developed under subsection (a) for—



1 (1) hypertension;
2 (2) hypercholesterolemia;
3 (3) diabetes;
4 (4) cardiovascular disease;
5 (5) prostate cancer;
6 (6) breast cancer;
7 (7) colon cancer;
8 (8) kidney disease;
9 (9) glaucoma; and
10 (10) other diseases determined appropriate by
11 the Secretary.

12 (d) DISSEMINATION.—Not later than 24 months
13 after the date of enactment of this title, the Secretary
14 shall publish and disseminate to healthcare provider orga-
15 nizations the guidelines developed under subsection (a).

16 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated to carry out this section,
18 sums as may be necessary for each of fiscal years 2007
19 through 2012.

20 **SEC. 442. CANCER REDUCTION.**

21 (a) PREVENTIVE HEALTH MEASURES WITH RE-
22 SPECT TO BREAST AND CERVICAL CANCER.—

23 (1) IN GENERAL.—Section 1510(a) of the Pub-
24 lic Health Service Act (42 U.S.C. 300n–5(a)) is
25 amended by striking “2005” and inserting “2012”.



1 (2) SUPPLEMENTAL GRANTS FOR ADDITIONAL
2 PREVENTIVE HEALTH SERVICES.—Section
3 1509(d)(1) of the Public Health Service Act (42
4 U.S.C. 300n–4a(d)(1)) is amended by striking
5 “2005” and inserting “2012”.

6 (b) TREATMENT AND PREVENTION.—Title XXIX of
7 the Public Health Service Act, as amended by section 312,
8 is further amended by adding at the end the following:

9 **“Subtitle B—Reducing Disease and**
10 **Disease-related Complications**

11 **“SEC. 2921. CANCER PREVENTION AND TREATMENT FOR**
12 **UNDERSERVED MINORITY OR OTHER POPU-**
13 **LATIONS.**

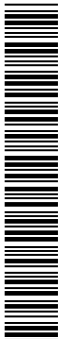
14 “(a) GRANTS.—The Secretary may make grants to
15 qualifying health centers, non-profit organizations, and
16 public institutions for the development, expansion, or oper-
17 ation of programs that, for individuals otherwise served
18 by such centers, provide—

19 “(1) information and education on cancer pre-
20 vention;

21 “(2) screenings for cancer;

22 “(3) counseling on cancer, including counseling
23 upon a diagnosis of cancer; and

24 “(4) treatment for cancer.



1 “(b) QUALIFYING HEALTH CENTERS AND PUBLIC
2 INSTITUTIONS.—For purposes of this section:

3 “(1) QUALIFYING HEALTH CENTERS.—The
4 term ‘qualifying health center’ includes community
5 health centers, migrant health centers, health cen-
6 ters for the homeless, health centers for residents of
7 public housing, and community clinics.

8 “(2) QUALIFYING PUBLIC INSTITUTIONS.—The
9 term ‘qualifying public institutions’ means an entity
10 that meets the requirements of section 2971(b)(1).

11 “(c) PREFERENCE IN MAKING GRANTS.—In making
12 grants under subsection (a), the Secretary shall give pref-
13 erence to applicants that—

14 “(1) have service populations that include a sig-
15 nificant number of low-income minority individuals
16 who are at-risk for cancer;

17 “(2) will, through programs under subsection
18 (b)—

19 “(A) emphasize early detection of and com-
20 prehensive treatment for cancer;

21 “(B) provide comprehensive treatment
22 services for cancer in its earliest stages; and

23 “(C) carry out subparagraphs (A) and (B)
24 for two or more types of cancer; and



1 “(3) in order to provide treatment for cancer,
2 have established or will establish referral arrange-
3 ments with entities that provide screenings for low-
4 income individuals.

5 “(d) APPROPRIATE CULTURAL CONTEXT.—As a con-
6 dition for the receipt of a grant under subsection (a), the
7 applicant shall agree that, in the program carried out with
8 the grant, services will be provided in the languages most
9 appropriate for, and with consideration for the cultural
10 background of, the individuals for whom the services are
11 provided.

12 “(e) OUTREACH SERVICES.—As a condition for the
13 receipt of a grant under subsection (a), the applicant shall
14 agree to provide outreach activities to inform the public
15 of the services of the program, and to provide information
16 on cancer; and

17 “(f) APPLICATION FOR GRANT.—A grant may be
18 made under subsection (a) only if an application for the
19 grant is submitted to the Secretary and the application
20 is in such form, is made in such manner, and contains
21 such agreements, assurances, and information as the Sec-
22 retary determines to be necessary to carry out this section.

23 “(g) DESIGNATION OF TYPE OF CANCER.—In mak-
24 ing a grant under subsection (a), the Secretary shall des-



1 ignite the type or types of cancer with respect to which
2 the grant is being made.

3 “(h) AUTHORIZATION OF APPROPRIATIONS.—For the
4 purpose of carrying out this section, there are authorized
5 to be appropriated such sums as may be necessary for
6 each of the fiscal years 2005 through 2010.”.

7 **SEC. 443. MONITORING THE QUALITY OF AND DISPARITIES**
8 **IN DIABETES CARE.**

9 Part A of title IX of the Public Health Service Act
10 (42 U.S.C. 299 et seq.) is amended by adding at the end
11 the following:

12 **“SEC. 904. AREAS OF SPECIAL EMPHASIS.**

13 “The Secretary, acting through the Director, shall in-
14 corporate within the annual quality report required under
15 section 913(b)(2) and the annual disparities report re-
16 quired under section 903(a)(6), scientific evidence and in-
17 formation appropriate for monitoring the quality and safe-
18 ty of diabetes care and identifying, understanding, and re-
19 ducing disparities in care.”.

20 **SEC. 444. DIABETES PREVENTION, TREATMENT, AND CON-**
21 **TROL.**

22 (a) DETERMINATION.—The Secretary, in consulta-
23 tion with Indian tribes and tribal organizations, shall
24 determine—



1 (1) by tribe, tribal organization, and service
2 unit of the Service, the prevalence of, and the types
3 of complications resulting from, diabetes among In-
4 dians; and

5 (2) based on paragraph (1), the measures (in-
6 cluding patient education) each service unit should
7 take to reduce the prevalence of, and prevent, treat,
8 and control the complications resulting from, diabe-
9 tes among Indian tribes within that service unit.

10 (b) SCREENING.—The Secretary shall screen each In-
11 dian who receives services from the Service for diabetes
12 and for conditions which indicate a high risk that the indi-
13 vidual will become diabetic. Such screening may be done
14 by an Indian tribe or tribal organization operating
15 healthcare programs or facilities with funds from the Serv-
16 ice under the Indian Self-Determination and Education
17 Assistance Act.

18 (c) CONTINUED FUNDING.—The Secretary shall con-
19 tinue to fund, through fiscal year 2015, each effective
20 model diabetes project in existence on the date of the en-
21 actment of this Act and such other diabetes programs op-
22 erated by the Secretary or by Indian tribes and tribal or-
23 ganizations and any additional programs added to meet
24 existing diabetes needs. Indian tribes and tribal organiza-
25 tions shall receive recurring funding for the diabetes pro-



1 grams which they operate pursuant to this section. Model
2 diabetes projects shall consult, on a regular basis, with
3 tribes and tribal organizations in their regions regarding
4 diabetes needs and provide technical expertise as needed.

5 (d) DIALYSIS PROGRAMS.—The Secretary shall pro-
6 vide funding through the Service, Indian tribes and tribal
7 organizations to establish dialysis programs, including
8 funds to purchase dialysis equipment and provide nec-
9 essary staffing.

10 (e) OTHER ACTIVITIES.—The Secretary shall, to the
11 extent funding is available—

12 (1) in each area office of the Service, consult
13 with Indian tribes and tribal organizations regarding
14 programs for the prevention, treatment, and control
15 of diabetes;

16 (2) establish in each area office of the Service
17 a registry of patients with diabetes to track the
18 prevalence of diabetes and the complications from
19 diabetes in that area; and

20 (3) ensure that data collected in each area of-
21 fice regarding diabetes and related complications
22 among Indians is disseminated to tribes, tribal orga-
23 nizations, and all other area offices.



1 (f) DEFINITIONS.—For purposes of this section, the
2 definitions contained in section 4 of the Indian Health
3 Care Improvement Act shall apply.

4 **SEC. 445. GENETICS OF DIABETES.**

5 Title IV of the Public Health Service Act (42 U.S.C.
6 281 et seq.) is amended by inserting after section 430 the
7 following:

8 **“SEC. 430A. GENETICS OF DIABETES.**

9 “The Diabetes Mellitus Interagency Coordinating
10 Committee, in collaboration with the Directors of the Na-
11 tional Human Genome Research Institute, the National
12 Institute of Diabetes and Digestive and Kidney Diseases,
13 and the National Institute of Environmental Health
14 Sciences, and other voluntary organizations and interested
15 parties, shall—

16 “(1) coordinate and assist efforts of the Type
17 1 Diabetes Genetics Consortium, which will collect
18 and share valuable DNA information from type 1 di-
19 abetes patients from studies around the world; and

20 “(2) provide continued coordination and sup-
21 port for the consortia of laboratories investigating
22 the genomics of diabetes.”.



1 **SEC. 446. RESEARCH AND TRAINING ON DIABETES IN UN-**
2 **DERSERVED AND MINORITY POPULATIONS.**

3 (a) RESEARCH.—Subpart 3 of part C of title IV of
4 the Public Health Service Act (42 U.S.C. 285c et seq.)
5 is amended by adding at the end the following:

6 **“SEC. 434B. RESEARCH ON DIABETES IN UNDERSERVED**
7 **AND MINORITY POPULATIONS.**

8 “(a) IN GENERAL.—The Director of the Institute, in
9 coordination with the Director of the National Center on
10 Minority Health and Health Disparities, the Director of
11 the Office of Minority Health, and other appropriate insti-
12 tutes and centers, shall expand, intensify, and coordinate
13 research programs on pre-diabetes, type 1 diabetes and
14 type 2 diabetes in underserved populations and minority
15 groups.

16 “(b) RESEARCH.—The research described in sub-
17 section (a) shall include research on—

18 “(1) behavior, including diet and physical activ-
19 ity and other aspects of behavior;

20 “(2) environmental factors related to type 2 di-
21 abetes that are unique to, more serious, or more
22 prevalent, among underserved or high-risk popu-
23 lations;

24 “(3) research on the prevention of complica-
25 tions, which are unique to, more serious, or more
26 prevalent among minorities, as well as research on



1 how to effectively translate the findings of clinical
2 trials and research to improve methods for self-man-
3 agement and health-care delivery; and

4 “(4) genetic studies of diabetes, consistent with
5 research conducted under section 430A.

6 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated for purposes of carrying
8 out this section, such sums as may be necessary for each
9 of fiscal years 2007 through 2012.”.

10 (b) DIVISION DIRECTORS.—Section 428(b)(1) of the
11 Public Health Service Act (42 U.S.C. 285c–2(b)(1)) is
12 amended by inserting “(including research training of
13 members of minority populations in order to facilitate
14 their conduct of diabetes-related research in underserved
15 populations and minority groups)” after “research pro-
16 grams”.

17 **SEC. 447. AUTHORIZATION OF APPROPRIATIONS.**

18 Subpart 3 of part C of title IV of the Public Health
19 Service Act (42 U.S.C. 285c et seq.) (as amended by sec-
20 tion 448(a)) is amended by adding at the end the fol-
21 lowing:

22 **“SEC. 434C. AUTHORIZATION OF APPROPRIATIONS.**

23 “For the purpose of carrying out this subpart with
24 respect to the programs of the National Institute of Diabe-
25 tes and Digestive and Kidney Diseases, other than section



1 434B, there are authorized to be appropriated such sums
2 as may be necessary for each of fiscal years 2007 through
3 2012.”.

4 **SEC. 448. PREVENTION AND CONTROL OF SEXUALLY**
5 **TRANSMITTED DISEASES.**

6 (a) IN GENERAL.—Section 318(e)(1) of the Public
7 Health Service Act (42 U.S.C. 247c(e)(1)) is amended by
8 striking “1998” and inserting “2008”.

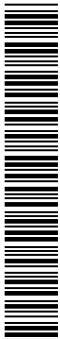
9 (b) PREVENTABLE CASES OF INFERTILITY.—Section
10 318A of the Public Health Service Act (42 U.S.C. 247c–
11 1) is amended—

12 (1) in subsection (q), by striking “1998” and
13 inserting “2012”; and

14 (2) in subsection (r)(2), by striking “1998” and
15 inserting “2012”.

16 **SEC. 449. MODEL COMMUNITY DIABETES AND CHRONIC**
17 **DISEASE CARE AND PREVENTION AMONG PA-**
18 **CIFIC ISLANDERS AND NATIVE HAWAIIANS.**

19 Part P of title III of the Public Health Service Act
20 (42 U.S.C. 280g et seq.), as amended by section 432, is
21 further amended by adding at the end the following:



1 **“SEC. 399P. MODEL COMMUNITY DIABETES AND CHRONIC**
2 **DISEASE CARE AND PREVENTION AMONG PA-**
3 **CIFIC ISLANDERS AND NATIVE HAWAIIANS.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Director of the Centers for Disease Control and Pre-
6 vention, may award grants and enter into cooperative
7 agreements and contracts with eligible entities to establish
8 a model community demonstration project to provide
9 training and support for community-based prevention and
10 control programs targeting diabetes, hypertension, cardio-
11 vascular disease, and other related health problems in
12 American Samoa, the Commonwealth of the Northern
13 Mariana Islands, Guam, the Federated States of Micro-
14 nesia, Hawaii, the Republic of the Marshall Islands, and
15 the Republic of Palau.

16 “(b) ELIGIBLE ENTITY DEFINED.—In this section
17 the term ‘eligible entity’ means any organization described
18 in section 501(c)(3) of the Internal Revenue Code of 1986
19 and exempt from tax under section 501(a) of such Code.

20 “(c) PRIORITY.—The Secretary shall give priority for
21 grants, agreements, and contracts under this section to
22 eligible entities that have previously administered cul-
23 turally appropriate Centers for Disease Control and Pre-
24 vention programs intended to prevent and control diabetes
25 in the areas described in subsection (a).



1 “(d) REGULATIONS.—The Secretary is authorized to
2 promulgate such regulations as may be necessary to carry
3 out this section.

4 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section,
6 such sums as may be necessary for fiscal years 2007
7 through 2012.”.

8 **SEC. 450. GRANTS TO IMPROVE THE PROVISION OF DENTAL**
9 **SERVICES UNDER MEDICAID AND SCHIP.**

10 Title V of the Social Security Act (42 U.S.C. 701
11 et seq.) is amended by adding at the end the following:

12 **“SEC. 511. GRANTS TO IMPROVE THE PROVISION OF DEN-**
13 **TAL SERVICES UNDER MEDICAID AND SCHIP.**

14 “(a) AUTHORITY TO MAKE GRANTS.—In addition to
15 any other payments made under this title to a State, the
16 Secretary shall award grants to States that satisfy the re-
17 quirements of subsection (b) to improve the provision of
18 dental services to children who are enrolled in a State plan
19 under title XIX or a State child health plan under title
20 XXI (in this section, collectively referred to as the ‘State
21 plans’).

22 “(b) REQUIREMENTS.—In order to be eligible for a
23 grant under this section, a State shall provide the Sec-
24 retary with the following assurances:



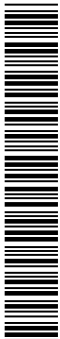
1 “(1) IMPROVED SERVICE DELIVERY.—The
2 State shall have a plan to improve the delivery of
3 dental services to children, including children with
4 special health care needs, who are enrolled in the
5 State plans, including providing outreach and ad-
6 ministrative case management, improving collection
7 and reporting of claims data, and providing incen-
8 tives, in addition to raising reimbursement rates, to
9 increase provider participation.

10 “(2) ADEQUATE PAYMENT RATES.—The State
11 has provided for payment under the State plans for
12 dental services for children at levels consistent with
13 the market-based rates and sufficient enough to en-
14 list providers to treat children in need of dental serv-
15 ices.

16 “(3) ENSURED ACCESS.—The State shall en-
17 sure it will make dental services available to children
18 enrolled in the State plans to the same extent as
19 such services are available to the general population
20 of the State.

21 “(c) USE OF FUNDS.—

22 “(1) IN GENERAL.—Funds provided under this
23 section may be used to provide administrative re-
24 sources (such as program development, provider
25 training, data collection and analysis, and research-



1 related tasks) to assist States in providing and as-
2 sessing services that include preventive and thera-
3 peutic dental care regimens.

4 “(2) LIMITATION.—Funds provided under this
5 section may not be used for payment of direct den-
6 tal, medical, or other services or to obtain Federal
7 matching funds under any Federal program.

8 “(d) APPLICATION.—A State shall submit an applica-
9 tion to the Secretary for a grant under this section in such
10 form and manner and containing such information as the
11 Secretary may require.

12 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to make grants under
14 this section, such sums as may be necessary for fiscal year
15 2007 and each fiscal year thereafter.

16 “(f) APPLICATION OF OTHER PROVISIONS OF
17 TITLE.—

18 “(1) IN GENERAL.—Except as provided in para-
19 graph (2), the other provisions of this title shall not
20 apply to a grant made under this section.

21 “(2) EXCEPTIONS.—The following provisions of
22 this title shall apply to a grant made under sub-
23 section (a) to the same extent and in the same man-
24 ner as such provisions apply to allotments made
25 under section 502(c):



1 “(A) Section 504(b)(6) (relating to prohi-
2 bition on payments to excluded individuals and
3 entities).

4 “(B) Section 504(c) (relating to the use of
5 funds for the purchase of technical assistance).

6 “(C) Section 504(d) (relating to a limita-
7 tion on administrative expenditures).

8 “(D) Section 506 (relating to reports and
9 audits), but only to the extent determined by
10 the Secretary to be appropriate for grants made
11 under this section.

12 “(E) Section 507 (relating to penalties for
13 false statements).

14 “(F) Section 508 (relating to non-
15 discrimination).

16 “(G) Section 509 (relating to the adminis-
17 tration of the grant program).”.

18 **SEC. 451. STATE OPTION TO PROVIDE WRAP-AROUND**
19 **SCHIP COVERAGE TO CHILDREN WHO HAVE**
20 **OTHER HEALTH COVERAGE.**

21 (a) IN GENERAL.—

22 (1) SCHIP.—

23 (A) STATE OPTION TO PROVIDE WRAP-
24 AROUND COVERAGE.—Section 2110(b) of the



1 Social Security Act (42 U.S.C. 1397jj(b)) is
2 amended—

3 (i) in paragraph (1)(C), by inserting
4 “, subject to paragraph (5),” after “under
5 title XIX or”; and

6 (ii) by adding at the end the fol-
7 lowing:

8 “(5) STATE OPTION TO PROVIDE WRAP-AROUND
9 COVERAGE.—A State may waive the requirement of
10 paragraph (1)(C) that a targeted low-income child
11 may not be covered under a group health plan or
12 under health insurance coverage, if the State satis-
13 fies the conditions described in subsection (c)(8).
14 The State may waive such requirement in order to
15 provide—

16 “(A) dental services;

17 “(B) cost-sharing protection; or

18 “(C) all services.

19 In waiving such requirement, a State may limit the
20 application of the waiver to children whose family in-
21 come does not exceed a level specified by the State,
22 so long as the level so specified does not exceed the
23 maximum income level otherwise established for
24 other children under the State child health plan.”.



1 (B) CONDITIONS DESCRIBED.—Section
2 2105(c) of the Social Security Act (42 U.S.C.
3 1397ee(c)) is amended by adding at the end the
4 following:

5 “(8) CONDITIONS FOR PROVISION OF WRAP-
6 AROUND COVERAGE.—For purposes of section
7 2110(b)(5), the conditions described in this para-
8 graph are the following:

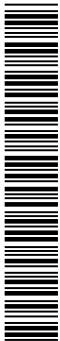
9 “(A) INCOME ELIGIBILITY.—The State
10 child health plan (whether implemented under
11 title XIX or this XXI)—

12 “(i) has the highest income eligibility
13 standard permitted under this title as of
14 January 1, 2002;

15 “(ii) subject to subparagraph (B),
16 does not limit the acceptance of applica-
17 tions for children; and

18 “(iii) provides benefits to all children
19 in the State who apply for and meet eligi-
20 bility standards.

21 “(B) NO WAITING LIST IMPOSED.—With
22 respect to children whose family income is at or
23 below 200 percent of the poverty line, the State
24 does not impose any numerical limitation, wait-
25 ing list, or similar limitation on the eligibility of



1 such children for child health assistance under
2 such State plan.

3 “(C) NO MORE FAVORABLE TREATMENT.—
4 The State child health plan may not provide
5 more favorable coverage of dental services to
6 the children covered under section 2110(b)(5)
7 than to children otherwise covered under this
8 title.”.

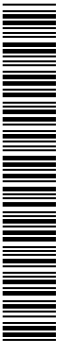
9 (C) STATE OPTION TO WAIVE WAITING PE-
10 RIOD.—Section 2102(b)(1)(B) of the Social Se-
11 curity Act (42 U.S.C. 1397bb(b)(1)(B)) is
12 amended—

13 (i) in clause (i), by striking “and” at
14 the end;

15 (ii) in clause (ii), by striking the pe-
16 riod and inserting “; and”; and

17 (iii) by adding at the end the fol-
18 lowing:

19 “(iii) at State option, may not apply
20 a waiting period in the case of a child de-
21 scribed in section 2110(b)(5), if the State
22 satisfies the requirements of section
23 2105(c)(8).”.



1 (2) APPLICATION OF ENHANCED MATCH UNDER
2 MEDICAID.—Section 1905 of the Social Security Act
3 (42 U.S.C. 1396d) is amended—

4 (A) in subsection (b), in the fourth sen-
5 tence, by striking “or subsection (u)(3)” and
6 inserting “(u)(3), or (u)(4)”; and

7 (B) in subsection (u)—

8 (i) by redesignating paragraph (4) as
9 paragraph (5); and

10 (ii) by inserting after paragraph (3)
11 the following:

12 “(4) For purposes of subsection (b), the ex-
13 penditures described in this paragraph are expendi-
14 tures for items and services for children described in
15 section 2110(b)(5), but only in the case of a State
16 that satisfies the requirements of section
17 2105(e)(8).”.

18 (3) APPLICATION OF SECONDARY PAYOR PROVI-
19 SIONS.—Section 2107(e)(1) of the Social Security
20 Act (42 U.S.C. 1397gg(e)(1)) is amended—

21 (A) by redesignating subparagraphs (B)
22 through (D) as subparagraphs (C) through (E),
23 respectively; and

24 (B) by inserting after subparagraph (A)
25 the following:



1 “(B) Section 1902(a)(25) (relating to co-
2 ordination of benefits and secondary payor pro-
3 visions) with respect to children covered under
4 a waiver described in section 2110(b)(5).”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 subsection (a) shall take effect on January 1, 2006, and
7 shall apply to child health assistance and medical assist-
8 ance provided on or after that date.

9 **SEC. 452. GRANTS TO IMPROVE THE PROVISION OF DENTAL**
10 **HEALTH SERVICES THROUGH COMMUNITY**
11 **HEALTH CENTERS AND PUBLIC HEALTH DE-**
12 **PARTMENTS.**

13 Part D of title III of the Public Health Service Act
14 (42 U.S.C. 254b et seq.) is amended by insert before sec-
15 tion 330, the following:

16 **“SEC. 329. GRANT PROGRAM TO EXPAND THE AVAIL-**
17 **ABILITY OF SERVICES.**

18 “(a) IN GENERAL.—The Secretary, acting through
19 the Health Resources and Services Administration, shall
20 establish a program under which the Secretary may award
21 grants to eligible entities and eligible individuals to expand
22 the availability of primary dental care services in dental
23 health professional shortage areas or medically under-
24 served areas.

25 “(b) ELIGIBILITY.—



1 “(1) ENTITIES.—To be eligible to receive a
2 grant under this section an entity—

3 “(A) shall be—

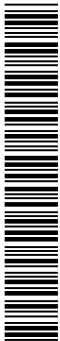
4 “(i) a health center receiving funds
5 under section 330 or designated as a Fed-
6 erally qualified health center;

7 “(ii) a county or local public health
8 department, if located in a federally-des-
9 ignated dental health professional shortage
10 area;

11 “(iii) an Indian tribe or tribal organi-
12 zation (as defined in section 4 of the In-
13 dian Self-Determination and Education
14 Assistance Act (25 U.S.C. 450b));

15 “(iv) a dental education program ac-
16 credited by the Commission on Dental Ac-
17 creditation; or

18 “(v) a community-based program
19 whose child service population is made up
20 of at least 33 percent of children who are
21 eligible children, including at least 25 per-
22 cent of such children being children with
23 mental retardation or related develop-
24 mental disabilities, unless specific docu-



1 mentation of a lack of need for access by
2 this sub-population is established; and

3 “(B) shall prepare and submit to the Sec-
4 retary an application at such time, in such
5 manner, and containing such information as the
6 Secretary may require, including information
7 concerning dental provider capacity to serve in-
8 dividuals with developmental disabilities.

9 “(2) INDIVIDUALS.—To be eligible to receive a
10 grant under this section an individual shall—

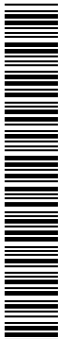
11 “(A) be a dental health professional li-
12 censed or certified in accordance with the laws
13 of State in which such individual provides den-
14 tal services;

15 “(B) prepare and submit to the Secretary
16 an application at such time, in such manner,
17 and containing such information as the Sec-
18 retary may require; and

19 “(C) provide assurances that—

20 “(i) the individual will practice in a
21 federally-designated dental health profes-
22 sional shortage area; or

23 “(ii) not less than 25 percent of the
24 patients of such individual are—



1 “(I) receiving assistance under a
2 State plan under title XIX of the So-
3 cial Security Act (42 U.S.C. 1396 et
4 seq.);

5 “(II) receiving assistance under a
6 State plan under title XXI of the So-
7 cial Security Act (42 U.S.C. 1397aa
8 et seq.); or

9 “(III) uninsured.

10 “(c) USE OF FUNDS.—

11 “(1) ENTITIES.—An entity shall use amounts
12 received under a grant under this section to provide
13 for the increased availability of primary dental serv-
14 ices in the areas described in subsection (a). Such
15 amounts may be used to supplement the salaries of-
16 fered for individuals accepting employment as den-
17 tists in such areas.

18 “(2) INDIVIDUALS.—A grant to an individual
19 under subsection (a) shall be in the form of a
20 \$1,000 bonus payment for each month in which such
21 individual is in compliance with the eligibility re-
22 quirements of subsection (b)(2)(C).

23 “(d) AUTHORIZATION OF APPROPRIATIONS.—

24 “(1) IN GENERAL.—Notwithstanding any other
25 amounts appropriated under section 330 for health



1 centers, there is authorized to be appropriated such
2 sums as may be necessary for each of fiscal years
3 2007 through 2012 to hire and retain dental
4 healthcare providers under this section.

5 “(2) USE OF FUNDS.—Of the amount appro-
6 priated for a fiscal year under paragraph (1), the
7 Secretary shall use—

8 “(A) not less than 65 percent of such
9 amount to make grants to eligible entities; and

10 “(B) not more than 35 percent of such
11 amount to make grants to eligible individuals.”.

12 **SEC. 453. PRIORITY SUBSTANCE ABUSE TREATMENT NEEDS**
13 **OF REGIONAL AND NATIONAL SIGNIFICANCE.**

14 Section 509 of the Public Health Service Act (42
15 U.S.C. 290bb-2) is amended—

16 (1) by redesignating subsection (f) as sub-
17 section (g); and

18 (2) by inserting after subsection (d) the fol-
19 lowing:

20 “(f) SPECIAL CONSIDERATION IN DEVELOPING PRO-
21 GRAM PRIORITIES.—The Secretary shall give special con-
22 sideration to promoting the integration of substance abuse
23 treatment services into primary health care systems and
24 the provision of culturally and linguistically appropriate



1 substance abuse treatment services in health disparity
2 populations.”.

3 **SEC. 454. FETAL ALCOHOL SYNDROME.**

4 Subtitle B of title XXIX of the Public Health Service
5 Act, as added by section 442, is amended by adding at
6 the end the following:

7 **“SEC. 2922. FETAL ALCOHOL SYNDROME.**

8 “(a) SURVEILLANCE AND IDENTIFICATION RE-
9 SEARCH.—The Secretary shall direct the National Center
10 for Birth Defects and Developmental Disabilities (referred
11 to in this section as the ‘Center’) to—

12 “(1) develop a uniform surveillance case defini-
13 tion for Fetal Alcohol Syndrome (referred to in this
14 section as ‘FAS’) and a uniform surveillance defini-
15 tion for Alcohol Related Neurodevelopmental Dis-
16 order (referred to in this section as ‘ARND’);

17 “(2) develop a comprehensive screening process
18 for FAS and ARND to include all age groups; and

19 “(3) disseminate the screening process devel-
20 oped under paragraph (2) to—

21 “(A) hospitals, outpatient programs, and
22 other healthcare providers;

23 “(B) incarceration and detainment facili-
24 ties;

25 “(C) primary and secondary schools;



1 “(D) social work and child welfare offices;

2 “(E) State offices and others providing
3 services to individuals with disabilities; and

4 “(F) others determined appropriate by the
5 Secretary.

6 “(b) CLINICAL CHARACTERIZATION OF FAS AND RE-
7 LATED DISEASES.—The Secretary shall direct the Na-
8 tional Institute of Alcohol Abuse and Alcoholism to—

9 “(1) research methods to quantify the central
10 nervous system impairments associated with fetal al-
11 cohool exposure and to develop clinical diagnostic
12 tools for the intellectual and behavioral problems as-
13 sociated with FAS and related diseases;

14 “(2) develop a neurocognitive phenotype for
15 FAS and ARND; and

16 “(3) include all relevant scientific and clinical
17 characterizations of FAS and related diseases in rel-
18 evant diagnostic codes.

19 “(c) COMMUNITY-BASED AND SUPPORT SERVICES
20 COORDINATION GRANTS.—The Secretary shall award
21 grants to States, Indian tribes and tribal organizations,
22 and nongovernmental organizations for the establishment
23 of—

24 “(1) pilot projects to identify and implement
25 best practices for—



1 “(A) educating children with fetal alcohol
2 spectrum disorders, including—

3 “(i) activities and programs designed
4 specifically for the identification, treat-
5 ment, and education of such children; and

6 “(ii) curricula development and
7 credentialing of teachers, administrators,
8 and social workers who implement such
9 programs;

10 “(B) educating judges, attorneys, child ad-
11 vocates, law enforcement officers, prison war-
12 dens, alternative incarceration administrators,
13 and incarceration officials on how to treat and
14 support individuals suffering from a fetal alco-
15 hol spectrum disorder within the criminal jus-
16 tice system, including—

17 “(i) programs designed specifically for
18 the identification, treatment, and education
19 of those with a fetal alcohol spectrum dis-
20 order; and

21 “(ii) curricula development and
22 credentialing within justice system for indi-
23 viduals who implement such programs; and

24 “(C) educating adoption or foster care
25 agency officials about available and necessary



1 services for children with fetal alcohol spectrum
2 disorders, including—

3 “(i) programs designed specifically for
4 the identification, treatment, and education
5 of those with a fetal alcohol spectrum dis-
6 order; and

7 “(ii) education and training for poten-
8 tial parents of an adopted child with a
9 fetal alcohol spectrum disorder;

10 “(2) nationally coordinated systems that inte-
11 grate transitional services for those affected by pre-
12 natal alcohol exposure such as housing assistance,
13 vocational training and placement, and medication
14 monitoring by—

15 “(A) providing training and support to
16 family services programs, children’s mental
17 health programs, and other local efforts;

18 “(B) recruiting and training mentors for
19 teenagers with a fetal alcohol spectrum dis-
20 order; and

21 “(C) maintaining a clearinghouse including
22 all relevant neurobehavioral information needed
23 for supporting individuals with a fetal alcohol
24 spectrum disorder; and



1 “(3) programs to disseminate and coordinate
2 fetal alcohol spectrum disorder awareness and iden-
3 tification efforts by community health centers,
4 including—

5 “(A) education of health professionals re-
6 garding available support services; and

7 “(B) implementation of a tracking system
8 targeting the rates of fetal alcohol spectrum
9 disorders among individuals from certain racial,
10 ethnic, and economic backgrounds.

11 “(d) APPLICATION.—To be eligible to receive a grant
12 under subsection (g), an entity shall submit to the Sec-
13 retary an application in such form, in such manner, and
14 containing such agreements, assurances, and information
15 as the Secretary determines to be necessary to carry out
16 this section.

17 “(e) BUILDING STATE FASD SYSTEMS.—

18 “(1) IN GENERAL.—The Secretary, acting
19 through the Administrator of the Substance Abuse
20 and Mental Health Services Administration, shall
21 award grants, contracts, or cooperative agreements
22 to States for the purpose of establishing or expand-
23 ing statewide programs of surveillance, prevention,
24 and treatment of individuals with Fetal Alcohol
25 Spectrum Disorders.



1 “(2) ELIGIBILITY.—To be eligible to receive a
2 grant, contract, or cooperative agreement under
3 paragraph (1) a State shall—

4 “(A) prepare and submit to the Secretary
5 an application at such time, in such manner,
6 and containing such information as the Sec-
7 retary may reasonably require;

8 “(B) develop and implement a statewide
9 strategic plan for preventing and treating Fetal
10 Alcohol Spectrum Disorders;

11 “(C) consult with public and private non-
12 profit entities with relevant expertise on Fetal
13 Alcohol Spectrum Disorders within the State,
14 including—

15 “(i) parent-led groups and other orga-
16 nizations that support and advocate for in-
17 dividuals with Fetal Alcohol Spectrum Dis-
18 orders; and

19 “(ii) Indian tribes and tribal organiza-
20 tions; and

21 “(D) designate an individual to serve as
22 the coordinator of the State’s Fetal Alcohol
23 Spectrum Disorders program.



1 “(3) STRATEGIC PLAN.—The statewide stra-
2 tegic plan prepared under paragraph (2)(B) shall
3 include—

4 “(A) the identification of existing State
5 programs and systems that could be used to
6 identify and treat individuals with Fetal Alcohol
7 Spectrum Disorders and prevent alcohol con-
8 sumption during pregnancy, such as—

9 “(i) programs for the developmentally
10 disabled, the mentally ill, and individuals
11 with alcohol dependency;

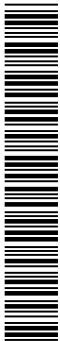
12 “(ii) primary and secondary edu-
13 cational systems;

14 “(iii) judicial systems for juveniles
15 and adults;

16 “(iv) child welfare programs and so-
17 cial service programs; and

18 “(v) other programs or systems the
19 State determines to be appropriate;

20 “(B) the identification of any barriers for
21 individuals with Fetal Alcohol Spectrum Dis-
22 orders or women at risk for alcohol consump-
23 tion during pregnancy to access the programs
24 identified under subparagraph (A); and



1 “(C) proposals to eliminate barriers to pre-
2 vention and treatment programs and coordinate
3 the activities of such programs.

4 “(4) USE OF FUNDS.—Amounts received under
5 a grant, contract, or cooperative agreement under
6 paragraph (1) shall be used for one or more of the
7 following activities:

8 “(A) Establishing a statewide surveillance
9 system.

10 “(B) Collecting, analyzing and interpreting
11 data.

12 “(C) Establishing a diagnostic center.

13 “(D) Developing, implementing, and evalu-
14 ating population-based and targeted prevention
15 programs for Fetal Alcohol Spectrum Dis-
16 orders, including public awareness campaigns.

17 “(E) Referring individuals with Fetal Alco-
18 hol Spectrum Disorders to appropriate support
19 services.

20 “(F) Developing and sharing best practices
21 for the prevention, identification, and treatment
22 of Fetal Alcohol Spectrum Disorders.

23 “(G) Providing training to health care pro-
24 viders on the prevention, identification, and
25 treatment of Fetal Alcohol Spectrum Disorders.



1 “(H) Disseminating information about
2 Fetal Alcohol Spectrum Disorders and the
3 availability of support services to families of in-
4 dividuals with Fetal Alcohol Spectrum Dis-
5 orders.

6 “(I) Other activities determined appro-
7 priate by the Secretary.

8 “(5) MULTI-STATE PROGRAMS.—The Secretary
9 shall permit the formation of multi-State Fetal Alco-
10 hol Spectrum Disorders programs under this sub-
11 section.

12 “(6) OTHER CONTRACTS AND AGREEMENTS.—
13 A State may carry out activities under paragraph
14 (4) through contacts or cooperative agreements with
15 public and private non-profit entities with a dem-
16 onstrated expertise in Fetal Alcohol Spectrum Dis-
17 orders.

18 “(7) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated to carry out
20 this subsection, such sums as may be necessary for
21 fiscal years 2006 through 2010.

22 “(f) PROMOTING COMMUNITY PARTNERSHIPS.—

23 “(1) IN GENERAL.—The Secretary shall award
24 grants, contracts, or cooperative agreements to eligi-
25 ble entities to enable such entities to establish, en-



1 hance, or improve community partnerships for the
2 purpose of collaborating on common objectives and
3 integrating the services available to individuals with
4 Fetal Alcohol Spectrum Disorders, such as surveil-
5 lance, prevention, treatment, and provision of sup-
6 port services.

7 “(2) ELIGIBLE ENTITIES.—To be eligible to re-
8 ceive a grant, contract, or cooperative agreement
9 under paragraph (1), an entity shall—

10 “(A) be a public or private nonprofit enti-
11 ty, including—

12 “(i) a health care provider or health
13 professional;

14 “(ii) a primary or secondary school;

15 “(iii) a social work or child welfare of-
16 fice;

17 “(iv) an incarceration or detainment
18 facility;

19 “(v) a parent-led group or other orga-
20 nization that supports and advocates for
21 individuals with Fetal Alcohol Spectrum
22 Disorders;

23 “(vi) an Indian tribe or tribal organi-
24 zation;



1 “(vii) any other entity the Secretary
2 determines to be appropriate; or

3 “(viii) a consortium of any of the enti-
4 ties described in clauses (i) through (vii);
5 and

6 “(B) prepare and submit to the Secretary
7 an application at such time, in such manner,
8 and containing such information as the Sec-
9 retary may reasonably require, including assur-
10 ances that the entity submitting the application
11 does, at the time of application, or will, within
12 a reasonable amount of time from the date of
13 application, include substantive participation of
14 a broad range of entities that work with or pro-
15 vide services for individuals with Fetal Alcohol
16 Spectrum Disorders.

17 “(3) ACTIVITIES.—An eligible entity shall use
18 amounts received under a grant, contract, or cooper-
19 ative agreement under this subsection shall carry out
20 1 or more of the following activities:

21 “(A) Identifying and integrating existing
22 programs and services available in the commu-
23 nity for individuals with Fetal Alcohol Spec-
24 trum Disorders.



1 “(B) Conducting a needs assessment to
2 identify services that are not available in a com-
3 munity.

4 “(C) Developing and implementing com-
5 munity-based initiatives to prevent, diagnose,
6 treat, and provide support services to individ-
7 uals with Fetal Alcohol Spectrum Disorders.

8 “(D) Disseminating information about
9 Fetal Alcohol Spectrum Disorders and the
10 availability of support services.

11 “(E) Developing and implementing a com-
12 munity-wide public awareness and outreach
13 campaign focusing on the dangers of drinking
14 alcohol while pregnant.

15 “(F) Providing mentoring or other support
16 to families of individuals with Fetal Alcohol
17 Spectrum Disorders.

18 “(G) Other activities determined appro-
19 priate by the Secretary.

20 “(4) AUTHORIZATION OF APPROPRIATION.—
21 There are authorized to be appropriated to carry out
22 this subsection, such sums as may be necessary for
23 each of fiscal years 2006 through 2010.

24 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
25 is authorized to be appropriated to carry out this section



1 (other than subsections (e) and (f)), such sums as may
2 be necessary for each of fiscal years 2005 through 2010.”.

3 **SEC. 455. HIV/AIDS REDUCTION.**

4 Subtitle B of title XXIX of the Public Health Service
5 Act, as amended by section 454, is amended by adding
6 at the end the following:

7 **“SEC. 2923. HIV/AIDS REDUCTION IN THE MINORITY COM-**
8 **MUNITY.**

9 “(a) EXPANDED FUNDING.—The Secretary, in col-
10 laboration with the Director of the Office of Minority
11 Health, the Director of the Centers for Disease Control
12 and Prevention, the Administrator of the Health Re-
13 sources and Services Administration, and the Adminis-
14 trator of the Substance Abuse and Mental Health Admin-
15 istration, shall provide funds and carry out activities to
16 expand the Minority HIV/AIDS Initiative.

17 “(b) USE OF FUNDS.—The additional funds made
18 available under this section may be used, through the Mi-
19 nority HIV/AIDS Initiative, to support the following ac-
20 tivities:

21 “(1) The provision of technical assistance and
22 infrastructure support to reduce HIV/AIDS in mi-
23 nority populations.

24 “(2) To increase minority populations’ access to
25 HIV/AIDS prevention and care services.



1 “(3) To build stronger community programs
2 and partnerships to address HIV prevention and the
3 healthcare needs of specific minority racial and eth-
4 nic populations.

5 “(c) PRIORITY INTERVENTIONS.—Within the minor-
6 ity populations referred to in subsection (b), priority in
7 conducting intervention services shall be given to—

8 “(1) women;

9 “(2) youth;

10 “(3) men who engage in homosexual activity;

11 “(4) persons who engage in intravenous drug
12 abuse;

13 “(5) homeless individuals; and

14 “(6) individuals incarcerated or in the penal
15 system.

16 “(d) AUTHORIZATION OF APPROPRIATIONS.—For the
17 purpose of carrying out this section, there are authorized
18 to be appropriated \$610,000,000 for fiscal year 2005, and
19 such sums as may be necessary for each of the fiscal years
20 2006 through 2010.”.

21 **SEC. 456. SYSTEMS FOR HEART DISEASE AND STROKE.**

22 Subtitle B of title XXIX of the Public Health Service
23 Act, as amended by section 455, is further amended by
24 adding at the end the following:



1 **“SEC. 2924. HEART DISEASE.**

2 “(a) IN GENERAL.—The Secretary, acting through
3 the National Heart, Lung and Blood Institute and the
4 Centers for Disease Control, shall award competitive
5 grants to eligible entities to provide for community-based
6 interventions to encourage healthy lifestyles to reduce
7 morbidity and mortality from heart disease.

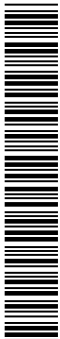
8 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
9 a grant under subsection (a), an entity shall—

10 “(1) be a community-based or non-profit orga-
11 nization, academic medical institution, hospital,
12 health center, health plan, health department, or
13 other health-related entity determined appropriate
14 by the Secretary; and

15 “(2) prepare and submit to the Secretary an
16 application at such time, in such manner, and con-
17 taining such information as the Secretary may re-
18 quire.

19 “(c) USE OF FUNDS.—An entity shall use amounts
20 received under a grant under this section to—

21 “(1) carry out interventions that address pri-
22 mary prevention of heart disease in the minority
23 community, including educational outreach efforts
24 concerning risk factors for, and the prevention of,
25 heart disease;



1 “(2) carry out activities to facilitate healthy
2 lifestyles in minority populations through—

3 “(A) behavioral change interventions to in-
4 crease physical activity and improve nutrition;

5 “(B) the increased use of community facili-
6 ties and public spaces for exercise;

7 “(C) school, after-school, or intramural
8 physical activity or sports programs for children
9 and youth;

10 “(D) employment-based interventions to
11 increase physical activity or nutrition; or

12 “(3) expand or evaluate existing programs of
13 the type described in paragraphs (1) and (2).

14 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section,
16 such sums as may be necessary for each of fiscal years
17 2006 through 2011.

18 **“SEC. 2925. STROKE EDUCATION CAMPAIGN.**

19 “(a) IN GENERAL.—The Secretary shall carry out a
20 national education and information campaign to promote
21 stroke prevention and increase the number of stroke pa-
22 tients who seek immediate treatment. In implementing
23 such education and information campaign, the Secretary
24 shall avoid duplicating existing stroke education efforts by
25 other Federal Government agencies and may consult with



1 national and local associations that are dedicated to in-
2 creasing the public awareness of stroke, consumers of
3 stroke awareness products, and providers of stroke care.

4 “(b) USE OF FUNDS.—The Secretary may use
5 amounts appropriated to carry out the campaign described
6 in subsection (a)—

7 “(1) to make public service announcements
8 about the warning signs of stroke and the impor-
9 tance of treating stroke as a medical emergency;

10 “(2) to provide education regarding ways to
11 prevent stroke and the effectiveness of stroke treat-
12 ment;

13 “(3) to purchase media time and space;

14 “(4) to pay for advertising production costs;

15 “(5) to test and evaluate advertising and edu-
16 cational materials for effectiveness, especially among
17 groups at high risk for stroke, including women,
18 older adults, and African-Americans;

19 “(6) to develop alternative campaigns that are
20 targeted to unique communities, including rural and
21 urban communities, and States with a particularly
22 high incidence of stroke;

23 “(7) to measure public awareness prior to the
24 start of the campaign on a national level and in tar-
25 geted communities to provide baseline data that will



1 be used to evaluate the effectiveness of the public
2 awareness efforts; and

3 “(8) to carry out other activities that the Sec-
4 retary determines will promote prevention practices
5 among the general public and increase the number
6 of stroke patients who seek immediate care.

7 “(c) CONSULTATIONS.—In carrying out this section,
8 the Secretary shall consult with medical, surgical, rehabili-
9 tation, and nursing specialty groups, hospital associations,
10 voluntary health organizations, emergency medical serv-
11 ices, State directors, and associations, experts in the use
12 of telecommunication technology to provide stroke care,
13 national disability, minority health professional organiza-
14 tions and consumer organizations representing individuals
15 with disabilities and chronic illnesses, concerned advo-
16 cates, and other interested parties.

17 “(d) STROKE.—In this section, the term ‘stroke’
18 means a ‘brain attack’ in which blood flow to the brain
19 is interrupted or in which a blood vessel or aneurysm in
20 the brain breaks or ruptures.

21 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out subsection
23 (b), such sums as may be necessary for each of fiscal years
24 2006 through 2011.”.



1 **Subtitle D—Studies, Reports, and**
2 **Plans**

3 **SEC. 461. IOM STUDY REQUEST.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services shall request that the Institute of Medi-
6 cine conduct, or contract with another entity to conduct,
7 a study to investigate promising strategies for improving
8 minority health and reducing and eliminating racial and
9 ethnic disparities in health and healthcare.

10 (b) CONTENT.—The study under subsection (a)
11 shall—

12 (1) identify key stakeholders for intervention in
13 the public and private sector;

14 (2) identify the barriers to eliminating racial
15 and ethnic disparities in health and healthcare;

16 (3) explore approaches for addressing dispari-
17 ties in health and healthcare using a quality im-
18 provement framework;

19 (4) suggest an evaluation and research agenda
20 that will advance effective strategies for reducing
21 and eliminating racial and ethnic disparities in
22 health and healthcare; and

23 (5) assess the capacity of the Department of
24 Health and Human Services, as currently struc-
25 tured, to implement and evaluate promising strate-



1 gies to improve minority health and reduce and
2 eliminate racial and ethnic disparities in health and
3 healthcare.

4 (c) AGENDA.—The agenda described in subsection
5 (b)(4) shall include a focus on the following:

6 (1) Observational studies of race-discordant and
7 race-concordant physician-patient clinical encoun-
8 ters.

9 (2) Studies of the behaviors and expressed atti-
10 tudes toward race and ethnicity during education
11 and training of health professionals.

12 (3) Expansion of prospective studies of dispari-
13 ties in care, combining clinical data with qualitative
14 interviews with patients and providers.

15 (4) Studies of the natural history of social cat-
16 egorization in medical education and practice.

17 (5) Studies of the effectiveness of standard clin-
18 ical guidelines in reducing disparities across disease
19 categories.

20 (6) Exploration of health system characteristics
21 that may contribute to or mitigate disparities in
22 health care.

23 (7) Evaluation of cultural competency programs
24 and their impact on the attitudes, knowledge, skills,
25 and behaviors of healthcare providers.



1 (8) Expansion of community-participatory re-
2 search with a focus on such topics as increasing
3 trust and patient empowerment.

4 (9) Studies on appropriate indicators of socio-
5 economic status, and methods for incorporating such
6 indicators in patient records.

7 (10) Interventional studies designed to elimi-
8 nate disparities.

9 (d) REPORT.—Not later than 24 months after the
10 date of enactment of this Act, the Secretary of Health and
11 Human Services shall submit to the appropriate commit-
12 tees of Congress a report containing the results of the
13 study conducted under subsection (a).

14 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to carry out this section,
16 such sums as may be necessary for each of fiscal years
17 2007 and 2008.

18 **SEC. 462. STRATEGIC PLAN.**

19 (a) IN GENERAL.—The Secretary, acting through the
20 Administrator of the Substance Abuse and Mental Health
21 Services Administration, shall formulate a strategic plan
22 for implementing the 2001 report by the Surgeon General
23 of the Public Health Service entitled “Mental Health: Cul-
24 ture, Race, and Ethnicity—A Supplement to Mental
25 Health: A Report of the Surgeon General” and the 2003



1 report by the President's New Freedom Commission on
2 Mental Health entitled "Achieving the Promise: Trans-
3 forming Mental Health Care in America".

4 (b) SUBMISSION.—Not later than 6 months after the
5 date of the enactment of this title, the Secretary shall sub-
6 mit to the Congress the strategic plan formulated under
7 this section.

8 **SEC. 463. ADVISORY COUNCIL FOR THE ELIMINATION OF**
9 **TUBERCULOSIS.**

10 Section 317E(f) of the Public Health Service Act (42
11 U.S.C. 247b–6(f)) is amended—

12 (1) by redesignating paragraph (5) as para-
13 graph (6); and

14 (2) by striking paragraphs (2) through (4), and
15 inserting the following:

16 “(2) DUTIES.—For the purpose of making
17 progress toward the goal of eliminating tuberculosis
18 from the United States, the Council shall provide to
19 the Secretary and other appropriate Federal officials
20 advice on coordinating the activities of the Public
21 Health Service and other Federal agencies that re-
22 late to such disease and on efficiently utilizing the
23 Federal resources involved.

24 “(3) NATIONAL PLAN.—In carrying out para-
25 graph (2), the Council, in consultation with appro-



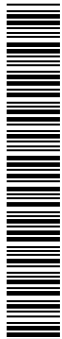
1 piate public and private entities, shall make rec-
2 ommendations on the development, revision, and im-
3 plementation of a national plan to eliminate tuber-
4 culosis in the United States. In carrying out this
5 paragraph, the Council shall—

6 “(A) consider the recommendations of the
7 Institute of Medicine regarding the elimination
8 of tuberculosis;

9 “(B) address the development and applica-
10 tion of new technologies; and

11 “(C) review the extent to which progress
12 has been made toward eliminating tuberculosis.

13 “(4) GLOBAL ACTIVITIES.—In carrying out
14 paragraph (2), the Council, in consultation with ap-
15 propriate public and private entities, shall make rec-
16 ommendations for the development and implementa-
17 tion of a plan to guide the involvement of the United
18 States in global and cross border tuberculosis-control
19 activities, including recommendations regarding poli-
20 cies, strategies, objectives, and priorities. Such rec-
21 ommendations for the plan shall have a focus on
22 countries where a high incidence of tuberculosis di-
23 rectly affects the United States, such as Mexico, and
24 on access to a comprehensive package of tuberculosis
25 control measures, as defined by the World Health



1 Organization directly observed treatment, short
2 course strategy (commonly known as DOTS).

3 “(5) COMPOSITION.—The Council shall be com-
4 posed of—

5 “(A) representatives from the Centers for
6 Disease Control and Prevention, the National
7 Institutes of Health, the Agency for Healthcare
8 Research and Quality, the Health Resources
9 and Services Administration, the U.S.-Mexico
10 Border Health Commission, and other Federal
11 departments and agencies that carry out signifi-
12 cant activities relating to tuberculosis; and

13 “(B) members appointed from among indi-
14 viduals who are not officers or employees of the
15 Federal Government.”.

16 **SEC. 464. NATIONAL PROGRAM FOR TUBERCULOSIS ELIMI-**
17 **NATION.**

18 Section 317E of the Public Health Service Act (42
19 U.S.C. 247b–6) is amended—

20 (1) by striking the heading for the section and
21 inserting the following: “**NATIONAL PROGRAM**
22 **FOR TUBERCULOSIS ELIMINATION**”;

23 (2) by amending subsection (b) to read as fol-
24 lows:



1 “(b) RESEARCH, DEMONSTRATION PROJECTS, EDU-
2 CATION, AND TRAINING.—With respect to the prevention,
3 control, and elimination of tuberculosis, the Secretary
4 may, directly or through grants to public or nonprofit pri-
5 vate entities, carry out the following:

6 “(1) Research, with priority given to research
7 concerning—

8 “(A) diagnosis and treatment of latent in-
9 fection of tuberculosis;

10 “(B) strains of tuberculosis resistant to
11 drugs;

12 “(C) cases of tuberculosis that affect cer-
13 tain high-risk populations; and

14 “(D) clinical trials, including those con-
15 ducted through the Tuberculosis Trials Consor-
16 tium.

17 “(2) Demonstration projects, including for—

18 “(A) the development of regional capabili-
19 ties for the prevention, control, and elimination
20 of tuberculosis particularly in low-incidence re-
21 gions; and

22 “(B) collaboration with the Immigration
23 and Naturalization Service to identify and treat
24 immigrants with active or latent tuberculosis in-
25 fection.



1 “(3) Public information and education pro-
2 grams.

3 “(4) Education, training and clinical skills im-
4 provement activities for health professionals, includ-
5 ing allied health personnel.

6 “(5) Support of model centers to carry out ac-
7 tivities under paragraphs (2) through (4).

8 “(6) Collaboration with international organiza-
9 tions and foreign countries, including Mexico, in co-
10 ordination with the United States Agency for Inter-
11 national Development, in carrying out such activi-
12 ties, including coordinating activities through the
13 Advisory Council for the Elimination of Tuber-
14 culosis.

15 “(7) Capacity support to States and large cities
16 for strengthening tuberculosis programs.”; and

17 (3) by striking subsection (g) and inserting the
18 following:

19 “(g) REPORTS.—The Secretary, acting through the
20 Director of the Centers for Disease Control and Preven-
21 tion and in consultation with the Advisory Council for the
22 Elimination of Tuberculosis, shall biennially prepare and
23 submit to the Committee on Health, Education, Labor,
24 and Pensions of the Senate and the Committee on Energy
25 and Commerce of the House of Representatives, a report



1 on the activities carried out under this section. Each re-
2 port shall include the opinion of the Council on the extent
3 to which its recommendations under section 317E(f)(3)
4 regarding tuberculosis have been implemented.

5 “(h) AUTHORIZATION OF APPROPRIATIONS.—For the
6 purpose of carrying out this section, there are authorized
7 to be appropriated such sums as may be necessary for
8 each of the fiscal years 2007 through 2012.”.

9 **SEC. 465. INCLUSION OF INPATIENT HOSPITAL SERVICES**
10 **FOR THE TREATMENT OF TB-INFECTED INDIVIDUALS.**
11

12 (a) IN GENERAL.—Section 1902(z)(2) of the Social
13 Security Act (42 U.S.C. 1396a(z)(2)) is amended by add-
14 ing at the end the following:

15 “(G) Inpatient hospital services.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) takes effect on October 1, 2006.

18 **Subtitle E—Miscellaneous**
19 **Provisions**

20 **SEC. 471. HEALTH EMPOWERMENT ZONES.**

21 (a) HEALTH EMPOWERMENT ZONE PROGRAMS.—

22 (1) GRANTS.—The Secretary, acting through
23 the Administrator of the Health Resources and Serv-
24 ices Administration and the Director of the Office of
25 Minority Health, and in cooperation with the Direc-



1 tor of the Office of Community Services and the Di-
2 rector of the National Center for Minority Health
3 and Health Disparities, shall make grants to part-
4 nerships of private and public entities to establish
5 health empowerment zone programs in communities
6 that disproportionately experience disparities in
7 health status and healthcare for the purpose de-
8 scribed in paragraph (2).

9 (2) USE OF FUNDS.—

10 (A) IN GENERAL.—Subject to subpara-
11 graph (B), the purpose of a health empower-
12 ment zone program under this section shall be
13 to assist individuals, businesses, schools, minor-
14 ity health associations, non-profit organizations,
15 community-based organizations, hospitals,
16 healthcare clinics, foundations, and other enti-
17 ties in communities that disproportionately ex-
18 perience disparities in health status and
19 healthcare which are seeking—

20 (i) to improve the health or environ-
21 ment of minority individuals in the com-
22 munity and to reduce disparities in health
23 status and healthcare by assisting individ-
24 uals in accessing Federal programs; and



1 (ii) to coordinate the efforts of gov-
2 ernmental and private entities regarding
3 the elimination of racial and ethnic dispari-
4 ties in health status and healthcare.

5 (B) MEDICARE AND MEDICAID.—A health
6 empowerment zone program under this section
7 shall not provide any assistance (other than re-
8 ferral and follow-up services) that is duplicative
9 of programs under title XVIII or XIX of the
10 Social Security Act (42 U.S.C. 1395 and 1396
11 et seq.).

12 (3) DISTRIBUTION.—The Secretary shall make
13 at least 1 grant under this section to a partnership
14 for a health empowerment zone program in commu-
15 nities that disproportionately experience disparities
16 in health status and healthcare that is located in a
17 territory or possession of the United States.

18 (4) APPLICATION.—To obtain a grant under
19 this section, a partnership shall submit to the Sec-
20 retary an application in such form and in such man-
21 ner as the Secretary may require. An application
22 under this paragraph shall—

23 (A) demonstrate that the communities to
24 be served by the health empowerment zone pro-



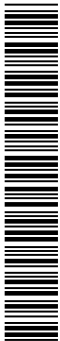
1 gram are those that disproportionately experi-
2 ence disparities in health status and healthcare;

3 (B) set forth a strategic plan for accom-
4 plishing the purpose described in paragraph (2),
5 by—

6 (i) describing the coordinated health,
7 economic, human, community, and physical
8 development plan and related activities
9 proposed for the community;

10 (ii) describing the extent to which
11 local institutions and organizations have
12 contributed and will contribute to the plan-
13 ning process and implementation;

14 (iii) identifying the projected amount
15 of Federal, State, local, and private re-
16 sources that will be available in the area
17 and the private and public partnerships to
18 be used (including any participation by or
19 cooperation with universities, colleges,
20 foundations, non-profit organizations, med-
21 ical centers, hospitals, health clinics, school
22 districts, or other private and public enti-
23 ties);



1 (iv) identifying the funding requested
2 under any Federal program in support of
3 the proposed activities;

4 (v) identifying benchmarks for meas-
5 uring the success of carrying out the stra-
6 tegic plan;

7 (vi) demonstrating the ability to reach
8 and service the targeted underserved mi-
9 nority community populations in a cul-
10 turally appropriate and linguistically re-
11 sponsive manner; and

12 (vii) demonstrating a capacity and in-
13 frastructure to provide long-term commu-
14 nity response that is culturally appropriate
15 and linguistically responsive to commu-
16 nities that disproportionately experience
17 disparities in health and healthcare; and

18 (C) include such other information as the
19 Secretary may require.

20 (5) PREFERENCE.—In awarding grants under
21 this subsection, the Secretary shall give preference
22 to proposals from indigenous community entities
23 that have an expertise in providing culturally appro-
24 priate and linguistically responsive services to com-



1 communities that disproportionately experience dispari-
2 ties in health and health care.

3 (b) FEDERAL ASSISTANCE FOR HEALTH EMPOWER-
4 MENT ZONE GRANT PROGRAMS.—The Secretary, the Ad-
5 ministrator of the Small Business Administration, the
6 Secretary of Agriculture, the Secretary of Education, the
7 Secretary of Labor, and the Secretary of Housing and
8 Urban Development shall each—

9 (1) where appropriate, provide entity-specific
10 technical assistance and evidence-based strategies to
11 communities that disproportionately experience dis-
12 parities in health status and healthcare to further
13 the purposes served by a health empowerment zone
14 program established with a grant under subsection
15 (a);

16 (2) identify all programs administered by the
17 Department of Health and Human Services, Small
18 Business Administration, Department of Agri-
19 culture, Department of Education, Department of
20 Labor, and the Department of Housing and Urban
21 Development, respectively, that may be used to fur-
22 ther the purpose of a health empowerment zone pro-
23 gram established with a grant under subsection (a);
24 and



1 (3) in administering any program identified
2 under paragraph (2), consider the appropriateness of
3 giving priority to any individual or entity located in
4 communities that disproportionately experience dis-
5 parities in health status and healthcare served by a
6 health empowerment zone program established with
7 a grant under subsection (a), if such priority would
8 further the purpose of the health empowerment zone
9 program.

10 (c) HEALTH EMPOWERMENT ZONE COORDINATING
11 COMMITTEE.—

12 (1) ESTABLISHMENT.—For each health em-
13 powerment zone program established with a grant
14 under subsection (a), the Secretary acting through
15 the Director of Office of Minority Health and the
16 Administrator of the Health Resources and Services
17 Administration shall establish a health empowerment
18 zone coordinating committee.

19 (2) DUTIES.—Each coordinating committee es-
20 tablished, in coordination with the Director of the
21 Office of Minority Health and the Administrator of
22 the Health Resources and Services Administration,
23 shall provide technical assistance and evidence-based
24 strategies to the grant recipient involved, including
25 providing guidance on research, strategies, health



1 outcomes, program goals, management, implementa-
2 tion, monitoring, assessment, and evaluation proc-
3 esses.

4 (3) MEMBERSHIP.—

5 (A) APPOINTMENT.—The Director of the
6 Office of Minority Health and the Adminis-
7 trator of the Health Resources and Services Ad-
8 ministration, in consultation with the respective
9 grant recipient shall appoint the members of
10 each coordinating committee.

11 (B) COMPOSITION.—The Director of the
12 Office of Minority Health, and the Adminis-
13 trator of the Health Resources and Services Ad-
14 ministration shall ensure that each coordinating
15 committee established—

16 (i) has not more than 20 members;

17 (ii) includes individuals from commu-
18 nities that disproportionately experience
19 disparities in health status and healthcare;

20 (iii) includes community leaders and
21 leaders of community-based organizations;

22 (iv) includes representatives of aca-
23 demia and lay and professional organiza-
24 tions and associations including those hav-
25 ing expertise in medicine, technical, social



1 and behavioral science, health policy, advo-
2 cacy, cultural and linguistic competency,
3 research management, and organization;
4 and

5 (v) represents a reasonable cross-sec-
6 tion of knowledge, views, and application
7 of expertise on societal, ethical, behavioral,
8 educational, policy, legal, cultural, lin-
9 guistic, and workforce issues related to
10 eliminating disparities in health and
11 healthcare.

12 (C) INDIVIDUAL QUALIFICATIONS.—The
13 Director of the Office of Minority Health and
14 the Administrator of the Health Resources and
15 Services Administration may not appoint an in-
16 dividual to serve on a coordinating committee
17 unless the individual meets the following quali-
18 fications:

19 (i) The individual is not employed by
20 the Federal Government.

21 (ii) The individual has appropriate ex-
22 perience, including experience in the areas
23 of community development, cultural and
24 linguistic competency, reducing and elimi-



1 nating racial and ethnic disparities in
2 health and health care, or minority health.

3 (D) SELECTION.—In selecting individuals
4 to serve on a coordinating committee, the Di-
5 rector of Office of Minority Health and the Ad-
6 ministrator Health Resources and Services Ad-
7 ministration shall give due consideration to the
8 recommendations of the Congress, industry
9 leaders, the scientific community (including the
10 Institute of Medicine), academia, community
11 based non-profit organizations, minority health
12 and related organizations, the education com-
13 munity, State and local governments, and other
14 appropriate organizations.

15 (E) CHAIRPERSON.—The Director of the
16 Office of Minority Health and the Adminis-
17 trator of the Health Resources and Services Ad-
18 ministration, in consultation with the members
19 of the coordinating committee involved, shall
20 designate a chairperson of the coordinating
21 committee, who shall serve for a term of 3
22 years and who may be reappointed at the expi-
23 ration of each such term.

24 (F) TERMS.—Each member of a coordi-
25 nating committee shall be appointed for a term

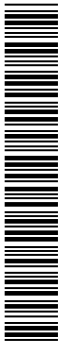


1 of 1 to 3 years in overlapping staggered terms,
2 as determined by the Director of the Office of
3 Minority Health and the Administrator of the
4 Health Resources and Services Administration
5 at the time of appointment, and may be re-
6 appointed at the expiration of each such term.

7 (G) VACANCIES.—A vacancy on a coordi-
8 nating committee shall be filled in the same
9 manner in which the original appointment was
10 made.

11 (H) COMPENSATION.—Each member of a
12 coordinating committee shall be compensated at
13 a rate equal to the daily equivalent of the an-
14 nual rate of basic pay for level IV of the Execu-
15 tive Schedule for each day (including travel
16 time) during which such member is engaged in
17 the performance of the duties of the coordi-
18 nating committee.

19 (I) TRAVEL EXPENSES.—Each member of
20 a coordinating committee shall receive travel ex-
21 penses, including per diem in lieu of subsist-
22 ence, in accordance with applicable provisions
23 under subchapter I of chapter 57 of title 5,
24 United States Code.



1 (4) MEETINGS.—A coordinating committee
2 shall meet 3 to 5 times each year, at the call of the
3 coordinating committee's chairperson and in con-
4 sultation with the Director of Office of Minority
5 Health and the Administrator Health Resources and
6 Services Administration.

7 (5) REPORT.—Each coordinating committee
8 shall transmit to the Congress an annual report
9 that, with respect to the health empowerment zone
10 program involved, includes the following:

11 (A) A review of the program's effectiveness
12 in achieving stated goals and outcomes.

13 (B) A review of the program's manage-
14 ment and the coordination of the entities in-
15 volved.

16 (C) A review of the activities in the pro-
17 gram's portfolio and components.

18 (D) An identification of policy issues raised
19 by the program.

20 (E) An assessment of the program's capac-
21 ity, infrastructure, and number of underserved
22 minority communities reached.

23 (F) Recommendations for new program
24 goals, research areas, enhanced approaches,
25 partnerships, coordination and management



1 mechanisms, and projects to be established to
2 achieve the program's stated goals, to improve
3 outcomes, monitoring, and evaluation.

4 (G) A review of the degree of minority en-
5 tity participation in the program, and an identi-
6 fication of a strategy to increase such participa-
7 tion.

8 (H) Any other reviews or recommendations
9 determined to be appropriate by the coordi-
10 nating committee.

11 (d) REPORT.—The Director of the Office of Minority
12 Health and the Administrator of the Health Resources
13 and Services Administration shall submit a joint annual
14 report to the appropriate committees of Congress on the
15 results of the implementation of programs under this sec-
16 tion.

17 (e) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section,
19 such sums as may be necessary for each of fiscal years
20 2007 through 2012.

21 **SEC. 472. OVERWEIGHT AND OBESITY PREVENTION AND**
22 **TREATMENT.**

23 (a) IN GENERAL.—The Secretary, in collaboration
24 with the Director of the Centers for Disease Control and
25 Prevention, the Administrator of the National Center for



1 Minority Health and Health Disparities, and the Adminis-
2 trator of the Health Resources and Services Administra-
3 tion, shall establish grant programs for the purpose of pre-
4 venting and treating overweight and obesity in under-
5 served minority populations.

6 (b) DEFINITIONS.—In this section, with respect to an
7 individual:

8 (1) OBESITY.—The term “obesity” means a
9 Body Mass Index greater than or equal to 30.0 kg/
10 m².

11 (2) OVERWEIGHT.—The term “overweight”
12 means a Body Mass Index of 25 to 29.9 kg/m².

13 (c) CENTERS FOR DISEASE CONTROL AND PREVEN-
14 TION.—The Director of the Centers for Disease Control
15 and Prevention shall expand overweight and obesity reduc-
16 tion activities that include the following:

17 (1) Surveillance in minority racial and ethnic
18 populations.

19 (2) Communication strategies, including the use
20 of social marketing for minority populations, about
21 the dangers of obesity.

22 (3) Creation of partnerships with State health
23 departments in developing obesity prevention and
24 treatment interventions.



1 (4) Development of work-based wellness pro-
2 grams to encourage adoption of healthy lifestyles by
3 employees.

4 (d) NATIONAL CENTER FOR MINORITY HEALTH AND
5 HEALTH DISPARITIES.—The Director of the Centers for
6 Disease Control and Prevention shall establish and imple-
7 ment a grant program to support research in the following
8 areas:

9 (1) Behavioral and environmental causes of
10 overweight and obesity in minority populations.

11 (2) Prevention and treatment interventions for
12 overweight and obesity, tailored for minority popu-
13 lations.

14 (3) Disparities in the prevalence of overweight
15 and obesity among racial and ethnic minority
16 groups.

17 (4) Development and dissemination of best
18 practice guidelines for treatment of overweight and
19 obesity, tailored for gender and age groups within
20 minority populations.

21 (5) Data collection and reporting relating to
22 overweight and obesity in minority populations.

23 (e) HEALTH RESOURCES AND SERVICES ADMINIS-
24 TRATION.—The Administrator of the Health Resources
25 and Services Administration, in collaboration with the Di-



1 rector of the Office of Minority Health, the Secretary of
2 Education, and the Secretary of Agriculture, shall estab-
3 lish and implement a school-based obesity prevention and
4 treatment program that may include the following activi-
5 ties:

6 (1) Projects to change the perception of over-
7 weight and obesity of children from racially and eth-
8 nically diverse backgrounds at all ages.

9 (2) Culturally appropriate student education
10 about healthy eating habits, based on the Dietary
11 Guidelines for Americans.

12 (3) Student programs to increase knowledge,
13 attitudes, skills, behaviors, and confidence needed to
14 be physically active for life.

15 (4) Student peer advisor programs to increase
16 awareness and model healthy lifestyles among fellow
17 students.

18 (5) Teacher education using scientifically evalu-
19 ated physical education and nutrition curricula tai-
20 lored to minority populations.

21 (6) Family-focused initiatives to encourage the
22 adoption of strategies relating to healthy lifestyles
23 for parents (or guardians) and children.

24 (7) The creation of partnerships with commu-
25 nity, fitness, or health organizations that will pro-



1 mote healthy eating and physical activity among
2 children.

3 (8) Incentive programs to ensure the provision
4 of healthful foods and beverages on school campuses
5 and at school events.

6 (f) EVALUATION.—A grantee under this section shall
7 submit to the Secretary an evaluation, in collaboration
8 with an academic health center or other qualified entity,
9 that describes activities carried out with funds received
10 under the grant and the effectiveness of such activities in
11 preventing or treating overweight and obesity.

12 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
13 authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2007 through 2012.

16 **SEC. 473. BORDER HEALTH GRANTS.**

17 (a) ELIGIBLE ENTITY DEFINED.—In this section,
18 the term “eligible entity” means a State, public institution
19 of higher education, local government, tribal government,
20 nonprofit health organization, community health center, or
21 community clinic receiving assistance under section 330
22 of the Public Health Service Act (42 U.S.C. 254b), that
23 is located in the border area.

24 (b) AUTHORIZATION.—From funds appropriated
25 under subsection (f), the Secretary, acting through the



1 United States members of the United States-Mexico Bor-
2 der Health Commission, shall award grants to eligible en-
3 tities to address priorities and recommendations to im-
4 prove the health of border area residents that are estab-
5 lished by—

6 (1) the United States members of the United
7 States-Mexico Border Health Commission;

8 (2) the State border health offices; and

9 (3) the Secretary.

10 (c) APPLICATION.—An eligible entity that desires a
11 grant under subsection (b) shall submit an application to
12 the Secretary at such time, in such manner, and con-
13 taining such information as the Secretary may require.

14 (d) USE OF FUNDS.—An eligible entity that receives
15 a grant under subsection (b) shall use the grant funds
16 for—

17 (1) programs relating to—

18 (A) maternal and child health;

19 (B) primary care and preventative health;

20 (C) public health and public health infra-
21 structure;

22 (D) health education and promotion;

23 (E) oral health;

24 (F) mental and behavioral health;

25 (G) substance abuse;



1 (H) health conditions that have a high
2 prevalence in the border area;

3 (I) medical and health services research;

4 (J) workforce training and development;

5 (K) community health workers or
6 promotoras;

7 (L) health care infrastructure problems in
8 the border area (including planning and con-
9 struction grants);

10 (M) health disparities in the border area;

11 (N) environmental health; and

12 (O) outreach and enrollment services with
13 respect to Federal programs (including pro-
14 grams authorized under titles XIX and XXI of
15 the Social Security Act (42 U.S.C. 1396 and
16 1397aa)); and

17 (2) other programs determined appropriate by
18 the Secretary.

19 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
20 vided to an eligible entity awarded a grant under sub-
21 section (b) shall be used to supplement and not supplant
22 other funds available to the eligible entity to carry out the
23 activities described in subsection (d).

24 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
25 authorized to be appropriated to carry out this section,



1 \$200,000,000 for fiscal year 2007, and such sums as may
2 be necessary for each succeeding fiscal year.

3 **SEC. 474. UNITED STATES-MEXICO BORDER HEALTH COM-**
4 **MISSION ACT AMENDMENTS.**

5 The United States-Mexico Border Health Commis-
6 sion Act (22 U.S.C. 290n et seq.) is amended by adding
7 at the end the following:

8 **“SEC. 9. AUTHORIZATION OF APPROPRIATIONS.**

9 “There is authorized to be appropriated to carry out
10 this Act \$10,000,000 for fiscal year 2007 and such sums
11 as may be necessary for each succeeding fiscal year.”.

12 **SEC. 475. PREVENTION AND CONTROL OF INJURIES.**

13 (a) IN GENERAL.—Section 394A of the Public
14 Health Service Act (42 U.S.C. 280b–3) is amended—

15 (1) by striking “and” after “1994,”;

16 (2) by striking “and” after “1998,”; and

17 (3) by striking “through 2005” and all that fol-
18 lows and inserting the following: “through 2006,
19 \$300,000,000 for fiscal year 2007, and such sums
20 as may be necessary for each of the fiscal years
21 2008 through 2012.”.

22 (b) DEMONSTRATION PROJECTS IN URBAN AREAS.—
23 Section 394A of the Public Health Service Act (42 U.S.C.
24 280b–3) is amended by adding at the end the following
25 sentence: “For the purpose of carrying out section



1 393(a)(6) in urban areas, there are authorized to be ap-
2 propriated such sums as may be necessary for each of the
3 fiscal years 2007 through 2012, in addition to amounts
4 available for such purpose pursuant to the preceding sen-
5 tence.”.

6 (c) DEMONSTRATION PROJECTS REGARDING VIO-
7 LENCE.—Section 393 of the Public Health Service Act (42
8 U.S.C. 280b–1a) is amended—

9 (1) by redesignating subsection (b) as sub-
10 section (c); and

11 (2) by inserting after subsection (a) the fol-
12 lowing subsection:

13 “(b) Grants under subsection (a)(6) shall include
14 grants to public or nonprofit private trauma centers for
15 demonstration projects to reduce violence.”.

16 **TITLE V—DATA COLLECTION** 17 **AND REPORTING**

18 **SEC. 501. AMENDMENT TO THE PUBLIC HEALTH SERVICE** 19 **ACT.**

20 (a) PURPOSE.—It is the purpose of this section to
21 promote data collection, analysis, and reporting by race,
22 ethnicity, and primary language among federally sup-
23 ported health programs.



1 (b) AMENDMENT.—Title XXIX of the Public Health
2 Service Act, as amended by titles II and III of this Act,
3 is further amended by adding at the end the following:

4 **“Subtitle C—Strengthening Data**
5 **Collection, Improving Data**
6 **Analysis, and Expanding Data**
7 **Reporting**

8 **“SEC. 2931. DATA ON RACE, ETHNICITY, AND PRIMARY LAN-**
9 **GUAGE.**

10 **“(a) REQUIREMENTS.—**

11 **“(1) IN GENERAL.—**Each health-related pro-
12 gram operated by or that receives funding or reim-
13 bursement, in whole or in part, either directly or in-
14 directly from the Department of Health and Human
15 Services shall—

16 **“(A) require the collection, by the agency**
17 **or program involved, of data on the race, eth-**
18 **nicity, and primary language of each applicant**
19 **for and recipient of health-related assistance**
20 **under such program—**

21 **“(i) using, at a minimum, the cat-**
22 **egories for race and ethnicity described in**
23 **the 1997 Office of Management and Budg-**
24 **et Standards for Maintaining, Collecting,**



1 and Presenting Federal Data on Race and
2 Ethnicity;

3 “(ii) using the standards developed
4 under subsection (e) for the collection of
5 language data;

6 “(iii) where practicable, collecting
7 data for additional population groups if
8 such groups can be aggregated into the
9 minimum race and ethnicity categories;
10 and

11 “(iv) where practicable, through self-
12 report;

13 “(B) with respect to the collection of the
14 data described in subparagraph (A) for appli-
15 cants and recipients who are minors or other-
16 wise legally incapacitated, require that—

17 “(i) such data be collected from the
18 parent or legal guardian of such an appli-
19 cant or recipient; and

20 “(ii) the preferred language of the
21 parent or legal guardian of such an appli-
22 cant or recipient be collected;

23 “(C) systematically analyze such data
24 using the smallest appropriate units of analysis
25 feasible to detect racial and ethnic disparities in



1 health and healthcare and when appropriate,
2 for men and women separately, and report the
3 results of such analysis to the Secretary, the
4 Director of the Office for Civil Rights, the Com-
5 mittee on Health, Education, Labor, and Pen-
6 sions and the Committee on Finance of the
7 Senate, and the Committee on Energy and
8 Commerce and the Committee on Ways and
9 Means of the House of Representatives;

10 “(D) provide such data to the Secretary on
11 at least an annual basis; and

12 “(E) ensure that the provision of assist-
13 ance to an applicant or recipient of assistance
14 is not denied or otherwise adversely affected be-
15 cause of the failure of the applicant or recipient
16 to provide race, ethnicity, and primary language
17 data.

18 “(2) RULES OF CONSTRUCTION.—Nothing in
19 this subsection shall be construed to—

20 “(A) permit the use of information col-
21 lected under this subsection in a manner that
22 would adversely affect any individual providing
23 any such information; and

24 “(B) require health care providers to col-
25 lect data.

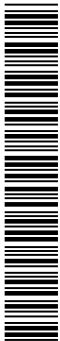


1 “(b) PROTECTION OF DATA.—The Secretary shall
2 ensure (through the promulgation of regulations or other-
3 wise) that all data collected pursuant to subsection (a) is
4 protected—

5 “(1) under the same privacy protections as the
6 Secretary applies to other health data under the reg-
7 ulations promulgated under section 264(c) of the
8 Health Insurance Portability and Accountability Act
9 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
10 lating to the privacy of individually identifiable
11 health information and other protections; and

12 “(2) from all inappropriate internal use by any
13 entity that collects, stores, or receives the data, in-
14 cluding use of such data in determinations of eligi-
15 bility (or continued eligibility) in health plans, and
16 from other inappropriate uses, as defined by the
17 Secretary.

18 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
19 Secretary shall develop and implement a national plan to
20 improve the collection, analysis, and reporting of racial,
21 ethnic, and primary language data at the Federal, State,
22 territorial, Tribal, and local levels, including data to be
23 collected under subsection (a). The Data Council of the
24 Department of Health and Human Services, in consulta-
25 tion with the National Committee on Vital Health Statis-



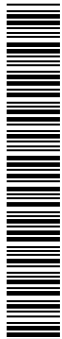
1 ties, the Office of Minority Health, and other appropriate
2 public and private entities, shall make recommendations
3 to the Secretary concerning the development, implementa-
4 tion, and revision of the national plan. Such plan shall
5 include recommendations on how to—

6 “(1) implement subsection (a) while minimizing
7 the cost and administrative burdens of data collec-
8 tion and reporting;

9 “(2) expand awareness among Federal agencies,
10 States, territories, Indian tribes, health providers,
11 health plans, health insurance issuers, and the gen-
12 eral public that data collection, analysis, and report-
13 ing by race, ethnicity, and primary language is legal
14 and necessary to assure equity and non-discrimina-
15 tion in the quality of healthcare services;

16 “(3) ensure that future patient record systems
17 have data code sets for racial, ethnic, and primary
18 language identifiers and that such identifiers can be
19 retrieved from clinical records, including records
20 transmitted electronically;

21 “(4) improve health and healthcare data collec-
22 tion and analysis for more population groups if such
23 groups can be aggregated into the minimum race
24 and ethnicity categories, including exploring the fea-
25 sibility of enhancing collection efforts in States for



1 racial and ethnic groups that comprise a significant
2 proportion of the population of the State;

3 “(5) provide researchers with greater access to
4 racial, ethnic, and primary language data, subject to
5 privacy and confidentiality regulations; and

6 “(6) safeguard and prevent the misuse of data
7 collected under subsection (a).

8 “(d) COMPLIANCE WITH STANDARDS.—Data col-
9 lected under subsection (a) shall be obtained, maintained,
10 and presented (including for reporting purposes) in ac-
11 cordance with the 1997 Office of Management and Budget
12 Standards for Maintaining, Collecting, and Presenting
13 Federal Data on Race and Ethnicity (at a minimum).

14 “(e) LANGUAGE COLLECTION STANDARDS.—Not
15 later than 1 year after the date of enactment of this title,
16 the Director of the Office of Minority Health, in consulta-
17 tion with the Office for Civil Rights of the Department
18 of Health and Human Services, shall develop and dissemi-
19 nate Standards for the Classification of Federal Data on
20 Preferred Written and Spoken Language.

21 “(f) TECHNICAL ASSISTANCE FOR THE COLLECTION
22 AND REPORTING OF DATA.—

23 “(1) IN GENERAL.—The Secretary may, either
24 directly or through grant or contract, provide tech-
25 nical assistance to enable a healthcare program or



1 an entity operating under such program to comply
2 with the requirements of this section.

3 “(2) TYPES OF ASSISTANCE.—Assistance pro-
4 vided under this subsection may include assistance
5 to—

6 “(A) enhance or upgrade computer tech-
7 nology that will facilitate racial, ethnic, and pri-
8 mary language data collection and analysis;

9 “(B) improve methods for health data col-
10 lection and analysis including additional popu-
11 lation groups beyond the Office of Management
12 and Budget categories if such groups can be
13 aggregated into the minimum race and ethnicity
14 categories;

15 “(C) develop mechanisms for submitting
16 collected data subject to existing privacy and
17 confidentiality regulations; and

18 “(D) develop educational programs to in-
19 form health insurance issuers, health plans,
20 health providers, health-related agencies, and
21 the general public that data collection and re-
22 porting by race, ethnicity, and preferred lan-
23 guage are legal and essential for eliminating
24 health and healthcare disparities.



1 “(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The
2 Secretary, acting through the Director of the Agency for
3 Healthcare Research and Quality and in coordination with
4 the Administrator of the Centers for Medicare and Med-
5 icaid Services, shall provide technical assistance to agen-
6 cies of the Department of Health and Human Services in
7 meeting Federal standards for race, ethnicity, and pri-
8 mary language data collection and analysis of racial and
9 ethnic disparities in health and healthcare in public pro-
10 grams by—

11 “(1) identifying appropriate quality assurance
12 mechanisms to monitor for health disparities;

13 “(2) specifying the clinical, diagnostic, or thera-
14 peutic measures which should be monitored;

15 “(3) developing new quality measures relating
16 to racial and ethnic disparities in health and
17 healthcare;

18 “(4) identifying the level at which data analysis
19 should be conducted; and

20 “(5) sharing data with external organizations
21 for research and quality improvement purposes.

22 “(h) NATIONAL CONFERENCE.—

23 “(1) IN GENERAL.—The Secretary shall spon-
24 sor a biennial national conference on racial, ethnic,
25 and primary language data collection to enhance co-



1 ordination, build partnerships, and share best prac-
2 tices in racial, ethnic, and primary language data
3 collection, analysis, and reporting.

4 “(2) REPORTS.—Not later than 6 months after
5 the date on which a national conference has con-
6 vened under paragraph (1), the Secretary shall pub-
7 lish in the Federal Register and submit to the Com-
8 mittee on Health, Education, Labor, and Pensions
9 and the Committee on Finance of the Senate and
10 the Committee on Energy and Commerce and the
11 Committee on Ways and Means of the House of
12 Representatives a report concerning the proceedings
13 and findings of the conference.

14 “(i) REPORT.—Not later than 2 years after the date
15 of enactment of this title, and biennially thereafter, the
16 Secretary shall submit to the appropriate committees of
17 Congress a report on the effectiveness of data collection,
18 analysis, and reporting on race, ethnicity, and primary
19 language under the programs and activities of the Depart-
20 ment of Health and Human Services and under other Fed-
21 eral data collection systems with which the Department
22 interacts to collect relevant data on race and ethnicity.
23 The report shall evaluate the progress made in the De-
24 partment with respect to the national plan under sub-
25 section (c) or subsequent revisions thereto.



1 “(j) GRANTS FOR DATA COLLECTION BY HEALTH
2 PLANS, HEALTH CENTERS, AND HOSPITALS.—

3 “(1) IN GENERAL.—The Secretary, in consulta-
4 tion with the Administrator of the Centers for Medi-
5 care and Medicaid Services, is authorized to award
6 grants for the conduct of 20 demonstration pro-
7 grams by health plans, health centers, or hospitals
8 to enhance their ability to collect, analyze, and re-
9 port the data required under subsection (a).

10 “(2) ELIGIBILITY.—To be eligible to receive a
11 grant under paragraph (1), a health plan or hospital
12 shall—

13 “(A) prepare and submit to the Secretary
14 an application at such time, in such manner,
15 and containing such information as the Sec-
16 retary may require, including a plan to elimi-
17 nate racial, ethnic, and primary language dis-
18 parities in health and healthcare through one or
19 more of the activities described in paragraph
20 (3); and

21 “(B) provide assurances that the health
22 plan or hospital will use, at a minimum, the ra-
23 cial and ethnic categories and the standards for
24 collection described in the 1997 Office of Man-
25 agement and Budget Standards for Maintain-



1 ing, Collecting, and Presenting Federal Data on
2 Race and Ethnicity and available standards for
3 language.

4 “(3) ACTIVITIES.—A grantee shall use amounts
5 received under a grant under paragraph (1) to—

6 “(A) collect, analyze, and report data by
7 race, ethnicity, and primary language for pa-
8 tients served by the hospital (including emer-
9 gency room patients and patients served on an
10 outpatient basis) or health center, or, in the
11 case of a private health plan, such data for en-
12 rollees;

13 “(B) enhance or upgrade computer tech-
14 nology that will facilitate racial, ethnic, and pri-
15 mary language data collection and analysis;

16 “(C) provide analyses of racial and ethnic
17 disparities in health and healthcare, including
18 specific disease conditions, diagnostic and
19 therapeutic procedures, or outcomes;

20 “(D) improve health data collection and
21 analysis for additional population groups be-
22 yond the Office of Management and Budget
23 categories if such groups can be aggregated into
24 the minimum race and ethnicity categories;



1 “(E) develop mechanisms for sharing col-
2 lected data subject to privacy and confiden-
3 tiality regulations;

4 “(F) develop educational programs to in-
5 form health insurance issuers, health plans,
6 health providers, health-related agencies, pa-
7 tients, enrollees, and the general public that
8 data collection, analysis, and reporting by race,
9 ethnicity, and preferred language are legal and
10 essential for eliminating disparities in health
11 and healthcare; and

12 “(G) develop quality assurance systems de-
13 signed to track disparities and quality improve-
14 ment systems designed to eliminate disparities.

15 “(I) DEFINITION.—In this section, the term ‘health-
16 related program’ mean a program—

17 “(1) under the Social Security Act (42 U.S.C.
18 301 et seq.) that pay for healthcare and services;
19 and

20 “(2) under this Act that provide Federal finan-
21 cial assistance for healthcare, biomedical research,
22 health services research, and programs designed to
23 improve the public’s health.

24 “(m) AUTHORIZATION OF APPROPRIATIONS.—There
25 is authorized to be appropriated to carry out this section,



1 such sums as may be necessary for each of fiscal years
2 2007 through 2012.

3 **“SEC. 2932. PROVISIONS RELATING TO NATIVE AMERICANS.**

4 “(a) EPIDEMIOLOGY CENTERS.—

5 “(1) ESTABLISHMENT.—

6 “(A) IN GENERAL.—In addition to those
7 centers operating 1 day prior to the date of en-
8 actment of this title, (including those centers
9 for which funding is currently being provided
10 through funding agreements under the Indian
11 Self-Determination and Education Assistance
12 Act), the Secretary shall, not later than 180
13 days after such date of enactment, establish
14 and fund an epidemiology center in each service
15 area which does not have such a center to carry
16 out the functions described in subparagraph
17 (B). Any centers established under the pre-
18 ceding sentence may be operated by Indian
19 tribes or tribal organizations pursuant to fund-
20 ing agreements under the Indian Self-Deter-
21 mination and Education Assistance Act, but
22 funding under such agreements may not be di-
23 visible.

24 “(B) FUNCTIONS.—In consultation with
25 and upon the request of Indian tribes, tribal or-



1 ganizations and urban Indian organizations,
2 each area epidemiology center established under
3 this subsection shall, with respect to such area
4 shall—

5 “(i) collect data related to the health
6 status objective described in section 3(b) of
7 the Indian Health Care Improvement Act,
8 and monitor the progress that the Service,
9 Indian tribes, tribal organizations, and
10 urban Indian organizations have made in
11 meeting such health status objective;

12 “(ii) evaluate existing delivery sys-
13 tems, data systems, and other systems that
14 impact the improvement of Indian health;

15 “(iii) assist Indian tribes, tribal orga-
16 nizations, and urban Indian organizations
17 in identifying their highest priority health
18 status objectives and the services needed to
19 achieve such objectives, based on epidemio-
20 logical data;

21 “(iv) make recommendations for the
22 targeting of services needed by tribal,
23 urban, and other Indian communities;



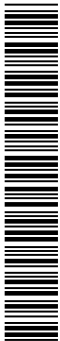
1 “(v) make recommendations to im-
2 prove healthcare delivery systems for Indi-
3 ans and urban Indians;

4 “(vi) provide requested technical as-
5 sistance to Indian tribes and urban Indian
6 organizations in the development of local
7 health service priorities and incidence and
8 prevalence rates of disease and other ill-
9 ness in the community; and

10 “(vii) provide disease surveillance and
11 assist Indian tribes, tribal organizations,
12 and urban Indian organizations to promote
13 public health.

14 “(C) TECHNICAL ASSISTANCE.—The direc-
15 tor of the Centers for Disease Control and Pre-
16 vention shall provide technical assistance to the
17 centers in carrying out the requirements of this
18 subsection.

19 “(2) FUNDING.—The Secretary may make
20 funding available to Indian tribes, tribal organiza-
21 tions, and eligible intertribal consortia or urban In-
22 dian organizations to conduct epidemiological studies
23 of Indian communities.



1 “(b) DEFINITIONS.—For purposes of this section, the
2 definitions contained in section 4 of the Indian Health
3 Care Improvement Act shall apply.”.

4 **SEC. 502. COLLECTION OF RACE AND ETHNICITY DATA BY**
5 **THE SOCIAL SECURITY ADMINISTRATION.**

6 Part A of title XI of the Social Security Act (42
7 U.S.C. 1301 et seq.) is amended by adding at the end
8 the following:

9 **“SEC. 1150A. COLLECTION OF RACE AND ETHNICITY DATA**
10 **BY THE SOCIAL SECURITY ADMINISTRATION.**

11 “(a) REQUIREMENT.—The Commissioner of the So-
12 cial Security Administration in consultation with the Ad-
13 ministrator of the Centers for Medicare and Medicaid
14 Services shall—

15 “(1) require the collection of data on the race,
16 ethnicity, and primary language of all applicants for
17 social security numbers, social security income, so-
18 cial security disability, and medicare—

19 “(A) using, at a minimum, the categories
20 for race and ethnicity described in the 1997 Of-
21 fice of Management and Budget Standards for
22 Maintaining, Collecting, and Presenting Federal
23 Data on Race and Ethnicity and available lan-
24 guage standards; and



1 “(B) where practicable, collecting data for
2 additional population groups if such groups can
3 be aggregated into the minimum race and eth-
4 nicity categories;

5 “(2) with respect to the collection of the data
6 described in paragraph (1) for applicants who are
7 under 18 years of age or otherwise legally incapac-
8 tated, require that—

9 “(A) such data be collected from the par-
10 ent or legal guardian of such an applicant; and

11 “(B) the primary language of the parent
12 or legal guardian of such an applicant or recipi-
13 ent be used;

14 “(3) require that such data be uniformly ana-
15 lyzed and reported at least annually to the Commis-
16 sioner of Social Security;

17 “(4) be responsible for storing the data re-
18 ported under paragraph (3);

19 “(5) ensure transmission to the Centers for
20 Medicare and Medicaid Services and other Federal
21 health agencies;

22 “(6) provide such data to the Secretary on at
23 least an annual basis; and

24 “(7) ensure that the provision of assistance to
25 an applicant is not denied or otherwise adversely af-



1 fected because of the failure of the applicant to pro-
2 vide race, ethnicity, and primary language data.

3 “(b) PROTECTION OF DATA.—The Commissioner of
4 Social Security shall ensure (through the promulgation of
5 regulations or otherwise) that all data collected pursuant
6 subsection (a) is protected—

7 “(1) under the same privacy protections as the
8 Secretary applies to other health data under the reg-
9 ulations promulgated under section 264(c) of the
10 Health Insurance Portability and Accountability Act
11 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
12 lating to the privacy of individually identifiable
13 health information and other protections; and

14 “(2) from all inappropriate internal use by any
15 entity that collects, stores, or receives the data, in-
16 cluding use of such data in determinations of eligi-
17 bility (or continued eligibility) in health plans, and
18 from other inappropriate uses, as defined by the
19 Secretary.

20 “(c) NATIONAL EDUCATION PROGRAM.—Not later
21 than 18 months after the date of enactment of this sec-
22 tion, the Secretary, acting through the Director of the Of-
23 fice of Minority Health and in collaboration with the Com-
24 missioner of the Social Security Administration, shall de-
25 velop and implement a program to educate all populations



1 about the purpose and uses of racial, ethnic, and primary
2 language health data collection.

3 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
4 tion shall be construed to permit the use of information
5 collected under this section in a manner that would ad-
6 versely affect any individual providing any such informa-
7 tion.

8 “(e) TECHNICAL ASSISTANCE.—The Secretary may,
9 either directly or by grant or contract, provide technical
10 assistance to enable any health entity to comply with the
11 requirements of this section.

12 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2007 through 2012.”.

16 **SEC. 503. REVISION OF HIPAA CLAIMS STANDARDS.**

17 (a) IN GENERAL.—Not later than 1 year after the
18 date of enactment of this Act, the Secretary of Health and
19 Human Services shall revise the regulations promulgated
20 under part C of title XI of the Social Security Act (42
21 U.S.C. 1320d et seq.), as added by the Health Insurance
22 Portability and Accountability Act of 1996 (Public Law
23 104–191), relating to the collection of data on race, eth-
24 nicity, and primary language in a health-related trans-
25 action to require—



1 (1) the use, at a minimum, of the categories for
2 race and ethnicity described in the 1997 Office of
3 Management and Budget Standards for Maintain-
4 ing, Collecting, and Presenting Federal Data on
5 Race and Ethnicity;

6 (2) the establishment of a new data code set for
7 primary language; and

8 (3) the designation of the racial, ethnic, and
9 primary language code sets as “required” for claims
10 and enrollment data.

11 (b) DISSEMINATION.—The Secretary of Health and
12 Human Services shall disseminate the new standards de-
13 veloped under subsection (a) to all health entities that are
14 subject to the regulations described in such subsection and
15 provide technical assistance with respect to the collection
16 of the data involved.

17 (c) COMPLIANCE.—The Secretary of Health and
18 Human Services shall require that health entities comply
19 with the new standards developed under subsection (a) not
20 later than 2 years after the final promulgation of such
21 standards.

22 **SEC. 504. NATIONAL CENTER FOR HEALTH STATISTICS.**

23 Section 306(n) of the Public Health Service Act (42
24 U.S.C. 242k(n)) is amended—



1 (1) in paragraph (1), by striking “2005” and
2 inserting “2012”;

3 (2) in paragraph (2), in the first sentence, by
4 striking “2005” and inserting “2012”; and

5 (3) in paragraph (3), by striking “2002” and
6 inserting “2012”.

7 **SEC. 505. GEO-ACCESS STUDY.**

8 The Administrator of the Substance Abuse and Men-
9 tal Health Services Administration shall—

10 (1) conduct a study to—

11 (A) determine which geographic areas of
12 the United States have shortages of specialty
13 mental health providers; and

14 (B) assess the preparedness of speciality
15 mental health providers to deliver culturally and
16 linguistically appropriate services; and

17 (2) submit a report to the Congress on the re-
18 sults of such study.

19 **TITLE VI—ACCOUNTABILITY**
20 **Subtitle A—General Provisions**

21 **SEC. 601. REPORT ON WORKFORCE DIVERSITY.**

22 (a) IN GENERAL.—Not later than July 1, 2007, and
23 annually thereafter, the Secretary, acting through the di-
24 rector of each entity within the Department of Health and
25 Human Services, shall prepare and submit to the Com-



1 mittee on Health, Education, Labor, and Pensions of the
2 Senate and the Committee on Energy and Commerce of
3 the House of Representatives a report on healthcare work-
4 force diversity.

5 (b) REQUIREMENT.—The report under subsection (a)
6 shall contain the following information:

7 (1) The response of the entity involved to the
8 2004 Institute of Medicine report entitled “In the
9 Nation’s Compelling Interest: Ensuring Diversity in
10 the Health Care Workforce”, the 2002 Institute of
11 Medicine report entitled “The Future of the Public
12 Health in the 21st Century”, and the Healthy Peo-
13 ple 2010 initiative.

14 (2) A description of the personnel in each such
15 entity who are responsible for overseeing workforce
16 diversity initiatives.

17 (3) The level of workforce diversity achieved
18 within each such entity, including absolute numbers
19 and percentages of minority employees as well as the
20 rank of such employees.

21 (4) A description of any grant support that is
22 provided by each entity for workforce diversity ini-
23 tiatives, including the amount of the grants and the
24 percentage of grant funds as compared to overall en-
25 tity funding;



1 (c) PUBLIC AVAILABILITY.—The report under sub-
2 section (a) shall be made available for public review and
3 comment.

4 **SEC. 602. FEDERAL AGENCY PLAN TO ELIMINATE DISPARI-**
5 **TIES AND IMPROVE THE HEALTH OF MINOR-**
6 **ITY POPULATIONS.**

7 (a) IN GENERAL.—Not later than September 1,
8 2007, each Federal health agency shall develop and imple-
9 ment a national strategic action plan to eliminate dispari-
10 ties on the basis of race, ethnicity, and primary language
11 and improve the health and healthcare of minority popu-
12 lations, through programs relevant to the mission of the
13 agency.

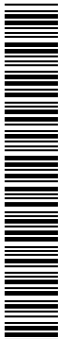
14 (b) PUBLICATION.—Each action plan described in
15 paragraph (1) shall—

16 (1) be publicly reported in draft form for public
17 review and comment;

18 (2) include a response to the review and com-
19 ment described in paragraph (1) in the final plan;

20 (3) include the agency response to the 2002 In-
21 stitute of Medicine report, Unequal Treatment—
22 Confronting Racial and Ethnic Disparities in
23 Healthcare;

24 (4) demonstrate progress in meeting the
25 Healthy People 2010 objectives; and



1 (5) be updated, including progress reports, for
2 inclusion in an annual report to Congress.

3 **SEC. 603. ACCOUNTABILITY WITHIN THE DEPARTMENT OF**
4 **HEALTH AND HUMAN SERVICES.**

5 Title XXIX of the Public Health Service Act, as
6 amended by titles II, III, and V of this Act, is further
7 amended by adding at the end the following:

8 **“Subtitle D—Strengthening**
9 **Accountability**

10 **“SEC. 2941. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

11 “(a) IN GENERAL.—The Secretary shall establish
12 within the Office for Civil Rights an Office of Health Dis-
13 parities, which shall be headed by a director to be ap-
14 pointed by the Secretary.

15 “(b) PURPOSE.—The Office of Health Disparities
16 shall ensure that the health programs, activities, and oper-
17 ations of health entities which receive Federal financial as-
18 sistance are in compliance with title VI of the Civil Rights
19 Act, which prohibits discrimination on the basis of race,
20 color, or national origin. The activities of the Office shall
21 include the following:

22 “(1) The development and implementation of
23 an action plan to address racial and ethnic
24 healthcare disparities, which shall address concerns
25 relating to the Office for Civil Rights as released by



1 the United States Commission on Civil Rights in the
2 report entitled 'Health Care Challenge: Acknowl-
3 edging Disparity, Confronting Discrimination, and
4 Ensuring Equity' (September, 1999). This plan shall
5 be publicly disclosed for review and comment and
6 the final plan shall address any comments or con-
7 cerns that are received by the Office.

8 “(2) Investigative and enforcement actions
9 against intentional discrimination and policies and
10 practices that have a disparate impact on minorities.

11 “(3) The review of racial, ethnic, and primary
12 language health data collected by Federal health
13 agencies to assess healthcare disparities related to
14 intentional discrimination and policies and practices
15 that have a disparate impact on minorities.

16 “(4) Outreach and education activities relating
17 to compliance with title VI of the Civil Rights Act.

18 “(5) The provision of technical assistance for
19 health entities to facilitate compliance with title VI
20 of the Civil Rights Act.

21 “(6) Coordination and oversight of activities of
22 the civil rights compliance offices established under
23 section 2942.

24 “(7) Ensuring compliance with the 1997 Office
25 of Management and Budget Standards for Maintain-



1 ing, Collecting, and Presenting Federal Data on
2 Race, Ethnicity and the available language stand-
3 ards.

4 “(c) FUNDING AND STAFF.—The Secretary shall en-
5 sure the effectiveness of the Office of Health Disparities
6 by ensuring that the Office is provided with—

7 “(1) adequate funding to enable the Office to
8 carry out its duties under this section; and

9 “(2) staff with expertise in—

10 “(A) epidemiology;

11 “(B) statistics;

12 “(C) health quality assurance;

13 “(D) minority health and health dispari-
14 ties; and

15 “(E) civil rights.

16 “(d) REPORT.—Not later than December 31, 2007,
17 and annually thereafter, the Secretary, in collaboration
18 with the Director of the Office for Civil Rights, shall sub-
19 mit a report to the Committee on Health, Education,
20 Labor, and Pensions of the Senate and the Committee on
21 Energy and Commerce of the House of Representatives
22 that includes—

23 “(1) the number of cases filed, broken down by
24 category;



1 “(2) the number of cases investigated and
2 closed by the office;

3 “(3) the outcomes of cases investigated; and

4 “(4) the staffing levels of the office including
5 staff credentials.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section,
8 such sums as may be necessary for each of fiscal years
9 2007 through 2012.

10 **“SEC. 2942. ESTABLISHMENT OF HEALTH PROGRAM OF-**
11 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
12 **HEALTH AND HUMAN SERVICES AGENCIES.**

13 “(a) IN GENERAL.—The Secretary shall establish
14 civil rights compliance offices in each agency within the
15 Department of Health and Human Services that admin-
16 isters health programs.

17 “(b) PURPOSE OF OFFICES.—Each office established
18 under subsection (a) shall ensure that recipients of Fed-
19 eral financial assistance under Federal health programs
20 administer their programs, services, and activities in a
21 manner that—

22 “(1) does not discriminate, either intentionally
23 or in effect, on the basis of race, national origin, lan-
24 guage, ethnicity, sex, age, or disability; and



1 “(2) promotes the reduction and elimination of
2 disparities in health and healthcare based on race,
3 national origin, language, ethnicity, sex, age, and
4 disability.

5 “(c) POWERS AND DUTIES.—The offices established
6 in subsection (a) shall have the following powers and du-
7 ties:

8 “(1) The establishment of compliance and pro-
9 gram participation standards for recipients of Fed-
10 eral financial assistance under each program admin-
11 istered by an agency within the Department of
12 Health and Human Services including the establish-
13 ment of disparity reduction standards to encompass
14 disparities in health and healthcare related to race,
15 national origin, language, ethnicity, sex, age, and
16 disability.

17 “(2) The development and implementation of
18 program-specific guidelines that interpret and apply
19 Department of Health and Human Services guid-
20 ance under title VI of the Civil Rights Act of 1964
21 to each Federal health program administered by the
22 agency.

23 “(3) The development of a disparity-reduction
24 impact analysis methodology that shall be applied to
25 every rule issued by the agency and published as



1 part of the formal rulemaking process under sections
2 555, 556, and 557 of title 5, United States Code.

3 “(4) Oversight of data collection, analysis, and
4 publication requirements for all recipients of Federal
5 financial assistance under each Federal health pro-
6 gram administered by the agency, and compliance
7 with the 1997 Office of Management and Budget
8 Standards for Maintaining, Collecting, and Pre-
9 senting Federal Data on Race and Ethnicity and the
10 available language standards.

11 “(5) The conduct of publicly available studies
12 regarding discrimination within Federal health pro-
13 grams administered by the agency as well as dis-
14 parity reduction initiatives by recipients of Federal
15 financial assistance under Federal health programs.

16 “(6) Annual reports to the Committee on
17 Health, Education, Labor, and Pensions and the
18 Committee on Finance of the Senate and the Com-
19 mittee on Energy and Commerce and the Committee
20 on Ways and Means of the House of Representatives
21 on the progress in reducing disparities in health and
22 healthcare through the Federal programs adminis-
23 tered by the agency.

24 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
25 IN THE DEPARTMENT OF JUSTICE.—



1 “(1) DEPARTMENT OF HEALTH AND HUMAN
2 SERVICES.—The Office for Civil Rights in the De-
3 partment of Health and Human Services shall pro-
4 vide standard-setting and compliance review inves-
5 tigation support services to the Civil Rights Compli-
6 ance Office for each agency.

7 “(2) DEPARTMENT OF JUSTICE.—The Office
8 for Civil Rights in the Department of Justice shall
9 continue to maintain the power to institute formal
10 proceedings when an agency Office for Civil Rights
11 determines that a recipient of Federal financial as-
12 sistance is not in compliance with the disparity re-
13 duction standards of the agency.

14 “(e) DEFINITION.—In this section, the term ‘Federal
15 health programs’ mean programs—

16 “(1) under the Social Security Act (42 U.S.C.
17 301 et seq.) that pay for healthcare and services;
18 and

19 “(2) under this Act that provide Federal finan-
20 cial assistance for healthcare, biomedical research,
21 health services research, and programs designed to
22 improve the public’s health.”.

23 **SEC. 604. OFFICE OF MINORITY HEALTH.**

24 Section 1707 of the Public Health Service Act (42
25 U.S.C. 300u-6) is amended—



1 (1) by striking the section heading and insert-
2 ing the following: “**OFFICE OF MINORITY**
3 **HEALTH AND RACIAL, ETHNIC, AND PRIMARY**
4 **LANGUAGE HEALTH DISPARITY ELIMINATION**”;

5 (2) by striking “Office of Minority Health”
6 each place such term appears and inserting “Office
7 of Minority Health and Racial, Ethnic, and Primary
8 Language Health Disparities Elimination”;

9 (3) by striking subsection (b) and inserting the
10 following:

11 “(b) DUTIES.—With respect to improving the health
12 of racial and ethnic minority groups, the Secretary, acting
13 through the Deputy Assistant Secretary for Minority
14 Health and Racial, Ethnic, and Primary Language Health
15 Disparities Elimination (in this section referred to as the
16 ‘Deputy Assistant Secretary’), shall carry out the fol-
17 lowing:

18 “(1) Establish, implement, monitor, and evalu-
19 ate short-range and long-range goals and objectives
20 and oversee all other activities within the Public
21 Health Service that relate to disease prevention,
22 health promotion, service delivery, and research con-
23 cerning minority groups. The heads of each of the
24 agencies of the Service shall consult with the Deputy



1 Assistant Secretary to ensure the coordination of
2 such activities.

3 “(2) Oversee all activities within the Depart-
4 ment of Health and Human Services that relate to
5 reducing or eliminating disparities in health and
6 healthcare in racial and ethnic minority populations,
7 including coordinating—

8 “(A) the design of programs, support for
9 programs, and the evaluation of programs;

10 “(B) the monitoring of trends in health
11 and healthcare;

12 “(C) research efforts;

13 “(D) the training of health providers; and

14 “(E) information and education programs
15 and campaigns.

16 “(3) Enter into interagency and intra-agency
17 agreements with other agencies of the Public Health
18 Service.

19 “(4) Ensure that the Federal health agencies
20 and the National Center for Health Statistics collect
21 data on the health status and healthcare of each mi-
22 nority group, using at a minimum the categories
23 specified in the 1997 OMB Standards for Maintain-
24 ing, Collecting, and Presenting Federal Data on



1 Race and Ethnicity as required under subtitle B and
2 available language standards.

3 “(5) Provide technical assistance to States,
4 local agencies, territories, Indian tribes, and entities
5 for activities relating to the elimination of racial and
6 ethnic disparities in health and healthcare.

7 “(6) Support a national minority health re-
8 source center to carry out the following:

9 “(A) Facilitate the exchange of informa-
10 tion regarding matters relating to health infor-
11 mation, health promotion and wellness, preven-
12 tive health services, and education in the appro-
13 priate use of health services.

14 “(B) Facilitate timely access to culturally
15 and linguistically appropriate information.

16 “(C) Assist in the analysis of such infor-
17 mation.

18 “(D) Provide technical assistance with re-
19 spect to the exchange of such information (in-
20 cluding facilitating the development of materials
21 for such technical assistance).

22 “(7) Carry out programs to improve access to
23 healthcare services for individuals with limited
24 English proficiency, including developing and car-
25 rying out programs to provide bilingual or interpre-



1 tive services through the development and support of
2 the Robert T. Matsui Center for Cultural and Lin-
3 guistic Competence in Healthcare as provided for in
4 section 2903.

5 “(8) Carry out programs to improve access to
6 healthcare services and to improve the quality of
7 healthcare services for individuals with low func-
8 tional health literacy. As used in the preceding sen-
9 tence, the term ‘functional health literacy’ means the
10 ability to obtain, process, and understand basic
11 health information and services needed to make ap-
12 propriate health decisions.

13 “(9) Advise in matters related to the develop-
14 ment, implementation, and evaluation of health pro-
15 fessions education on decreasing disparities in
16 healthcare outcomes, with focus on cultural com-
17 petency as a method of eliminating disparities in
18 health and healthcare in racial and ethnic minority
19 populations.

20 “(10) Assist healthcare professionals, commu-
21 nity and advocacy organizations, academic centers
22 and public health departments in the design and im-
23 plementation of programs that will improve the qual-
24 ity of health outcomes by strengthening the pro-
25 vider-patient relationship.”.



1 (2) by redesignating subsections (c) through (f)
2 and subsections (g) and (h) as subsections (d)
3 through (g) and subsections (j) and (k), respectively;
4 (3) by inserting after subsection (b), the fol-
5 lowing:

6 “(c) NATIONAL PLAN TO ELIMINATE RACIAL AND
7 ETHNIC HEALTH AND HEALTHCARE DISPARITIES.—

8 “(1) IN GENERAL.—The Secretary, acting
9 through the Deputy Assistant Secretary, shall—

10 “(A) not later than 1 year after the date
11 of enactment of the Healthcare Equality and
12 Accountability Act, establish and implement a
13 comprehensive plan to achieve the goal of
14 Healthy People 2010 to eliminate health dis-
15 parities in the United States;

16 “(B) establish the plan referred to in sub-
17 paragraph (A) in consultation with—

18 “(i) the Director of the Centers for
19 Disease Control and Prevention;

20 “(ii) the Director of the National In-
21 stitutes of Health;

22 “(iii) the Director of the National
23 Center on Minority Health and Health
24 Disparities;



1 “(iv) the Director of the Agency for
2 Healthcare Research and Quality;

3 “(v) the Administrator of the Health
4 Resources and Services Administration;

5 “(vi) the Administrator of the Centers
6 for Medicare and Medicaid Services;

7 “(vii) the Director of the Office for
8 Civil Rights;

9 “(viii) the Administrator of the Sub-
10 stance Abuse and Mental Health Services
11 Administration;

12 “(ix) the Commissioner of Food and
13 Drugs; and

14 “(x) the heads of other appropriate
15 public and private entities;

16 “(C) ensure that the plan includes measur-
17 able objectives, describes the means for achiev-
18 ing such objectives, and designates a date by
19 which such objectives are expected to be
20 achieved;

21 “(D) ensure that all amounts appropriated
22 for such activities are expended in accordance
23 with the plan;

24 “(E) review the plan on at least an annual
25 basis and revise the plan as appropriate;



1 “(F) ensure that the plan will serve as a
2 binding statement of policy with respect to the
3 agencies’ activities related to disparities in
4 health and healthcare; and

5 “(G) not later than March 1 of each year,
6 submit the plan (or any revisions to the plan),
7 to the Committee on Health, Education, Labor,
8 and Pensions of the Senate and the Committee
9 on Energy and Commerce of the House of Rep-
10 resentatives.

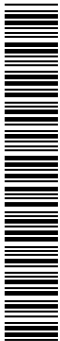
11 “(2) COMPONENTS OF THE PLAN.—The Deputy
12 Assistant Secretary shall ensure that the comprehen-
13 sive plan established under paragraph (1)
14 addresses—

15 “(A) the recommendations of the 2002 In-
16 stitute of Medicine report (Unequal Treatment)
17 with respect to racial and ethnic disparities in
18 healthcare;

19 “(B) health and disease prevention edu-
20 cation for racial, ethnic, and primary language
21 health disparity populations;

22 “(C) research to identify sources of health
23 and healthcare disparities in minority groups;

24 “(D) the implementation and assessment
25 of promising intervention strategies;



1 “(E) data collection and the monitoring of
2 the healthcare and health status of health dis-
3 parity populations;

4 “(F) care of individuals who lack pro-
5 ficiency with the English language;

6 “(G) care of individuals with low func-
7 tional health literacy;

8 “(H) the training, recruitment, and reten-
9 tion of minority health professionals;

10 “(I) programs to expand and facilitate ac-
11 cess to healthcare services, including the use of
12 telemedicine, National Health Service Scholars,
13 community health workers, and case managers;

14 “(J) public and health provider awareness
15 of racial and ethnic disparities in healthcare;

16 “(K) methods to evaluate and measure
17 progress toward the goal of eliminating dispari-
18 ties in health and healthcare in racial and eth-
19 nic minority populations;

20 “(L) the promotion of interagency and
21 intra-agency coordination and collaboration and
22 public-private and community partnerships; and

23 “(M) the preparedness of health profes-
24 sionals to care for racially, ethnically, and lin-
25 guistically diverse populations and low func-



1 tional health literacy populations including eval-
2 uations.”;

3 (4) in subsection (d) (as so redesignated)—

4 (A) in paragraph (1), by inserting “and
5 Racial, Ethnic, and Primary Language Health
6 Disparities Elimination” after “Minority
7 Health”; and

8 (B) in paragraph (2)—

9 (i) by striking “Deputy Assistant”;
10 and

11 (ii) by striking “(10) of subsection
12 (b)” and inserting “(9) of subsection (c)”;

13 (5) in subsection (e)(1) (as so redesignated)—

14 (A) in subparagraph (A), by striking “sub-
15 section (b)(9)” and inserting “subsection
16 (b)(7)”; and

17 (B) in subparagraph (B), by striking “sub-
18 section (b)(10)” and inserting “subsection
19 (b)(8)”;

20 (6) in subsection (f)(3) (as so redesignated), by
21 striking “subsection (f)” and inserting “subsection
22 (g)”;

23 (7) in subsection (g)(1) (as so redesignated)—

24 (A) by striking “1999 and each second”
25 and inserting “2006 and each”;



1 (B) by striking “Labor and Human Re-
2 sources” and inserting “Health, Education,
3 Labor, and Pensions”;

4 (C) by striking “2 fiscal years” and insert-
5 ing “fiscal year”; and

6 (D) by inserting after “improving the
7 health of racial and ethnic minority groups” the
8 following: “reducing and eliminating disparities
9 in health and healthcare in racial and ethnic
10 minority populations, in accordance with the
11 national plan specified under subsection (c) and
12 the goals of Healthy People 2010”;

13 (8) by inserting after subsection (g) (as so re-
14 designated) the following:

15 “(h) FEDERAL PARTNERSHIP WITH ACCREDITATION
16 ENTITIES.—

17 “(1) IN GENERAL.—Not later than 1 year after
18 the date of enactment of the Healthcare Equality
19 and Accountability Act, the Secretary, in collabora-
20 tion with the Director of the Agency for Healthcare
21 Research and Quality, the Administrator of the Cen-
22 ters for Medicare and Medicaid Services, the Direc-
23 tor of the Office for Minority Health, and the heads
24 of appropriate State agencies, shall convene a work-
25 ing group with members of accreditation organiza-



1 tions and other quality standard setting organiza-
2 tions to develop guidelines to evaluate and report on
3 the health and healthcare of minority populations
4 served by health centers, health plans, hospitals, and
5 other federally funded health entities.

6 “(2) REPORT.—Not later than 6 months after
7 the convening of the working group under paragraph
8 (1), the working group shall submit a report to the
9 Secretary at such time, in such manner, and con-
10 taining such information as the Secretary may re-
11 quire, including guidelines and recommendations on
12 how each accreditation body will work with con-
13 stituent members to ensure the adoption of such
14 guidelines.

15 “(3) DEMONSTRATION PROJECTS.—The Sec-
16 retary, acting through the Administrator of the Cen-
17 ters for Medicare and Medicaid Services, shall award
18 grants for the establishment of demonstration
19 projects to assess the impact of providing financial
20 incentives for the reporting and analysis of the qual-
21 ity of minority healthcare by hospitals, health plans,
22 health centers, and other healthcare entities.

23 “(4) AUTHORIZATION OF APPROPRIATIONS.—
24 There are authorized to be appropriated to carry out



1 this subsection, such sums as may be necessary for
2 each of fiscal years 2007 through 2012.

3 “(i) PREPARATION OF HEALTH PROFESSIONALS TO
4 PROVIDE HEALTHCARE TO MINORITY POPULATIONS.—
5 The Secretary, in collaboration with the Director of the
6 Bureau of Health Professions and the Director of the Of-
7 fice of Minority Health, shall require that health profes-
8 sional schools that receive Federal funds train future
9 health professionals to provide culturally and linguistically
10 appropriate healthcare to diverse populations.”; and

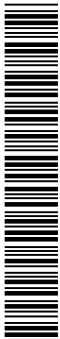
11 (9) by striking subsection (k) (as so redesign-
12 nated) and inserting the following:

13 “(k) AUTHORIZATION OF APPROPRIATIONS.—For the
14 purpose of carrying out this section (other than subsection
15 (h)), there is authorized to be appropriated \$100,000,000
16 for fiscal year 2006, and such sums as may be necessary
17 for each of fiscal years 2007 through 2012.”.

18 **SEC. 605. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
19 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
20 **SERVICE.**

21 (a) ESTABLISHMENT.—

22 (1) IN GENERAL.—In order to more effectively
23 and efficiently carry out the responsibilities, authori-
24 ties, and functions of the United States to provide
25 healthcare services to Indians and Indian tribes, as



1 are or may be hereafter provided by Federal statute
2 or treaties, there is established within the Public
3 Health Service of the Department of Health and
4 Human Services the Indian Health Service.

5 (2) ASSISTANT SECRETARY OF INDIAN
6 HEALTH.—The Service shall be administered by an
7 Assistant Secretary of Indian Health, who shall be
8 appointed by the President, by and with the advice
9 and consent of the Senate. The Assistant Secretary
10 shall report to the Secretary. Effective with respect
11 to an individual appointed by the President, by and
12 with the advice and consent of the Senate the term
13 of service of the Assistant Secretary shall be 4 years.
14 An Assistant Secretary may serve more than 1 term.

15 (b) AGENCY.—The Service shall be an agency within
16 the Public Health Service of the Department, and shall
17 not be an office, component, or unit of any other agency
18 of the Department.

19 (c) FUNCTIONS AND DUTIES.—The Secretary shall
20 carry out through the Assistant Secretary of the Service—

21 (1) all functions which were, on the day before
22 the date of enactment of the Indian Health Care
23 Amendments of 1988, carried out by or under the
24 direction of the individual serving as Director of the
25 Service on such day;



1 (2) all functions of the Secretary relating to the
2 maintenance and operation of hospital and health fa-
3 cilities for Indians and the planning for, and provi-
4 sion and utilization of, health services for Indians;

5 (3) all health programs under which healthcare
6 is provided to Indians based upon their status as In-
7 dians which are administered by the Secretary, in-
8 cluding programs under—

9 (A) the Indian Health Care Improvement
10 Act;

11 (B) the Act of November 2, 1921 (25
12 U.S.C. 13);

13 (C) the Act of August 5, 1954 (42 U.S.C.
14 2001, et seq.);

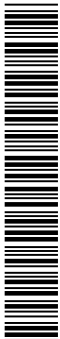
15 (D) the Act of August 16, 1957 (42
16 U.S.C. 2005 et seq.);

17 (E) the Indian Self-Determination Act (25
18 U.S.C. 450f, et seq.); and

19 (F) title XXIX of the Public Health Serv-
20 ice Act; and

21 (4) all scholarship and loan functions carried
22 out under title I of the Indian Health Care Improve-
23 ment Act.

24 (d) AUTHORITY.—



1 (1) IN GENERAL.—The Secretary, acting
2 through the Assistant Secretary, shall have the
3 authority—

4 (A) except to the extent provided for in
5 paragraph (2), to appoint and compensate em-
6 ployees for the Service in accordance with title
7 5, United States Code;

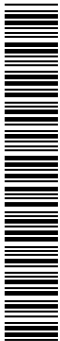
8 (B) to enter into contracts for the procure-
9 ment of goods and services to carry out the
10 functions of the Service; and

11 (C) to manage, expend, and obligate all
12 funds appropriated for the Service.

13 (2) PERSONNEL ACTIONS.—Notwithstanding
14 any other provision of law, the provisions of section
15 12 of the Act of June 18, 1934 (48 Stat. 986; 25
16 U.S.C. 472), shall apply to all personnel actions
17 taken with respect to new positions created within
18 the Service as a result of its establishment under
19 subsection (a).

20 (e) RATE OF PAY.—

21 (1) POSITIONS AT LEVEL IV.—Section 5315 of
22 title 5, United States Code, is amended by striking
23 the following: “Assistant Secretaries of Health and
24 Human Services (6).” and inserting “Assistant Sec-
25 retaries of Health and Human Services (7).”.



1 (2) POSITIONS AT LEVEL V.—Section 5316 of
2 such title is amended by striking the following: “Di-
3 rector, Indian Health Service, Department of Health
4 and Human Services.”.

5 (f) DUTIES OF ASSISTANT SECRETARY FOR INDIAN
6 HEALTH.—Section 601 of the Indian Health Care Im-
7 provement Act (25 U.S.C. 1661) is amended in subsection
8 (a)—

9 (1) by inserting “(1)” after “(a)”;

10 (2) in the second sentence of paragraph (1), as
11 so designated, by striking “a Director,” and insert-
12 ing “the Assistant Secretary for Indian Health,”;

13 (3) by striking the third sentence of paragraph
14 (1), as so designated, and all that follows through
15 the end of the subsection (a) of such section and in-
16 serting the following: “The Assistant Secretary for
17 Indian Health shall carry out the duties specified in
18 paragraph (2).”; and

19 (4) by adding after paragraph (1) the following:

20 “(2) The Assistant Secretary for Indian Health
21 shall—

22 “(A) report directly to the secretary con-
23 cerning all policy and budget-related matters
24 affecting Indian health;



1 “(B) collaborate with the Assistant Sec-
2 retary for Health concerning appropriate mat-
3 ters of Indian health that affect the agencies of
4 the Public Health Service;

5 “(C) advise each Assistant Secretary of the
6 Department of Health and Human Services
7 concerning matters of Indian health with re-
8 spect to which that Assistant Secretary has au-
9 thority and responsibility;

10 “(D) advise the heads of other agencies
11 and programs of the Department of Health and
12 Human Services concerning matters of Indian
13 health with respect to which those heads have
14 authority and responsibility; and

15 “(E) coordinate the activities of the De-
16 partment of Health and Human Services con-
17 cerning matters of Indian health.”.

18 (g) CONTINUED SERVICE BY INCUMBENT.—The indi-
19 vidual serving in the position of Director of the Indian
20 Health Service on the date preceding the date of enact-
21 ment of this Act may serve as Assistant Secretary for In-
22 dian Health, at the pleasure of the President after the
23 date of enactment of this Act.

24 (h) CONFORMING AMENDMENTS.—



1 (1) AMENDMENTS TO INDIAN HEALTH CARE IM-
2 PROVEMENT ACT.—The Indian Health Care Im-
3 provement Act (25 U.S.C. 1601 et seq.) is
4 amended—

5 (A) in section 601—

6 (i) in subsection (c), by striking “Di-
7 rector of the Indian Health Service” both
8 places it appears and inserting “Assistant
9 Secretary for Indian Health”; and

10 (ii) in subsection (d), by striking “Di-
11 rector of the Indian Health Service” and
12 inserting “Assistant Secretary for Indian
13 Health”; and

14 (B) in section 816(c)(1), by striking “Di-
15 rector of the Indian Health Service” and insert-
16 ing “Assistant Secretary for Indian Health”.

17 (2) AMENDMENTS TO OTHER PROVISIONS OF
18 LAW.—The following provisions are each amended
19 by striking “Director of the Indian Health Service”
20 each place it appears and inserting “Assistant Sec-
21 retary for Indian Health”:

22 (A) Section 203(a)(1) of the Rehabilitation
23 Act of 1973 (29 U.S.C. 761b(a)(1)).



1 (B) Subsections (b) and (e) of section 518
2 of the Federal Water Pollution Control Act (33
3 U.S.C. 1377 (b) and (e)).

4 (C) Section 803B(d)(1) of the Native
5 American Programs Act of 1974 (42 U.S.C.
6 2991b-2(d)(1)).

7 (i) REFERENCES.—Reference in any other Federal
8 law, Executive order, rule, regulation, or delegation of au-
9 thority, or any document of or relating to the Director
10 of the Indian Health Service shall be deemed to refer to
11 the Assistant Secretary for Indian Health.

12 (j) DEFINITIONS.—For purposes of this section, the
13 definitions contained in section 4 of the Indian Health
14 Care Improvement Act shall apply.

15 **SEC. 606. ESTABLISHMENT OF INDIVIDUAL OFFICES OF MI-**
16 **NORITY HEALTH WITHIN AGENCIES OF PUB-**
17 **LIC HEALTH SERVICE.**

18 Title XVII of the Public Health Service Act (42
19 U.S.C. 300u et seq.) is amended by inserting after section
20 1707 the following section:

21 “INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN
22 PUBLIC HEALTH SERVICE

23 “In General

24 “SEC. 1707A. (a) The head of each agency specified
25 in subsection (b)(1) shall establish within the agency an
26 office to be known as the Office of Minority Health and



1 Racial, Ethnic, and Primary Language Health Disparities
2 Elimination. Each such Office shall be headed by a direc-
3 tor, who shall be appointed by the head of the agency with-
4 in which the Office is established, and who shall report
5 directly to the head of the agency. The head of such agen-
6 cy shall carry out this section (as this section relates to
7 the agency) acting through such Director.

8 “Specified Agencies

9 “(b)

10 “(1) IN GENERAL.—The agencies referred to in
11 subsection (a) are the following:

12 “(A) The Centers for Disease Control and
13 Prevention.

14 “(B) The Health Resources and Services
15 Administration.

16 “(C) The Substance Abuse and Mental
17 Health Services Administration; and

18 “(D) The Administration on Aging.

19 “Composition

20 “(c) The head of each specified agency shall ensure
21 that the officers and employees of the minority health of-
22 fice of the agency are, collectively, experienced in carrying
23 out community-based health programs for each of the var-
24 ious racial and ethnic minority groups that are present
25 in significant numbers in the United States.



1 “Duties

2 “(d) Each Director of a minority health office shall
3 establish and monitor the programs of the specified agency
4 of such office in order to carry out the following:

5 “(1) Determine the extent to which the pur-
6 poses of the programs are being carried out with re-
7 spect to racial and ethnic minority groups;

8 “(2) Determine the extent to which members of
9 such groups are represented among the Federal offi-
10 cers and employees who administer the programs;
11 and

12 “(3) Make recommendations to the head of
13 such agency on carrying out the programs with re-
14 spect to such groups. In the case of programs that
15 provide services, such recommendations shall include
16 recommendations toward ensuring that—

17 “(A) the services are equitably delivered
18 with respect to racial and ethnic minority
19 groups;

20 “(B) the programs provide the services in
21 the language and cultural context that is most
22 appropriate for the individuals for whom the
23 services are intended; and



1 “(C) the programs utilize racial and ethnic
2 minority community-based organizations to de-
3 liver services.

4 “Biennial Reports to Secretary

5 “(e) The head of each specified agency shall submit
6 to the Secretary for inclusion in each biennial report
7 describing—

8 “(1) the extent to which the minority health of-
9 fice of the agency employs individuals who are mem-
10 bers of racial and ethnic minority groups, including
11 a specification by minority group of the number of
12 such individuals employed by such office.

13 “Funding

14 “(g)

15 “(1) ALLOCATIONS.—Of the amounts appro-
16 priated for a specified agency for a fiscal year, the
17 Secretary must designate an appropriate amount of
18 funds for the purpose of carrying out activities
19 under this section through the minority health office
20 of the agency. In reserving an amount under the
21 preceding sentence for a minority health office for a
22 fiscal year, the Secretary shall reduce, by substan-
23 tially the same percentage, the amount that other-
24 wise would be available for each of the programs of
25 the designated agency involved.



1 “(2) AVAILABILITY OF FUNDS FOR STAFF-
2 ING.—The purposes for which amounts made avail-
3 able under paragraph may be expended by a minor-
4 ity health office include the costs of employing staff
5 for such office.”.

6 **SEC. 607. OFFICE OF MINORITY HEALTH AT THE CENTERS**
7 **FOR MEDICARE AND MEDICAID SERVICES.**

8 (a) IN GENERAL.—Not later than 60 days after the
9 date of enactment of this Act, the Secretary of Health and
10 Human Services shall establish within the Centers for
11 Medicare and Medicaid Services an Office of Minority
12 Health (referred to in this section as the “Office”).

13 (b) DUTIES.—The Office shall be responsible for the
14 coordination and facilitation of activities of the Centers
15 for Medicare and Medicaid Services to improve minority
16 health and healthcare and to reduce racial and ethnic dis-
17 parities in health and healthcare, which shall include—

18 (1) creating a strategic plan, which shall be
19 made available for public review, to improve the
20 health and healthcare of Medicare, Medicaid, and
21 SCHIP beneficiaries;

22 (2) promoting agency-wide policies relating to
23 healthcare delivery and financing that could have a
24 beneficial impact on the health and healthcare of mi-
25 nority populations;



1 (3) assisting health plans, hospitals, and other
2 health entities in providing culturally and linguis-
3 tically appropriate healthcare services;

4 (4) increasing awareness and outreach activities
5 for minority healthcare consumers and providers
6 about the causes and remedies for health and
7 healthcare disparities;

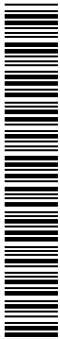
8 (5) developing grant programs and demonstra-
9 tion projects to identify, implement and evaluate in-
10 novative approaches to improving the health and
11 healthcare of minority beneficiaries in the Medicare,
12 Medicaid, and SCHIP programs;

13 (6) considering incentive programs relating to
14 reimbursement that would reward health entities for
15 providing quality healthcare for minority populations
16 using established benchmarks for quality of care;

17 (7) collaborating with the compliance office to
18 ensure compliance with the anti-discrimination provi-
19 sions under title VI of the Civil Rights Act of 1964;

20 (8) identifying barriers to enrollment in public
21 programs under the jurisdiction of the Centers for
22 Medicare and Medicaid Services;

23 (9) monitoring and evaluating on a regular
24 basis the success of minority health programs and
25 initiatives;



1 (10) publishing an annual report about the ac-
2 tivities of the Centers for Medicare and Medicaid
3 Services relating to minority health improvement;
4 and

5 (11) other activities determined appropriate by
6 the Secretary of Health and Human Services.

7 (c) STAFF.—The staff at the Office shall include—

8 (1) one or more individuals with expertise in
9 minority health and racial and ethnic health dispari-
10 ties; and

11 (2) one or more individuals with expertise in
12 healthcare financing and delivery in underserved
13 communities.

14 (d) COORDINATION.—In carrying out its duties under
15 this section, the Office shall coordinate with—

16 (1) the Office of Minority Health in the Office
17 of the Secretary of Health and Human Services;

18 (2) the National Centers for Minority Health
19 and Health Disparities in the National Institutes of
20 Health; and

21 (3) the Office of Minority Health in the Centers
22 for Disease Control and Prevention.

23 (e) AUTHORIZATION OF APPROPRIATIONS.—For the
24 purpose of carrying out this section, there are authorized
25 to be appropriated \$10,000,000 for fiscal year 2006, and



1 such sums may be necessary for each of fiscal years 2007
2 through 2012.

3 **SEC. 608. OFFICE OF MINORITY AFFAIRS AT THE FOOD AND**
4 **DRUG ADMINISTRATION.**

5 Chapter IX of the Federal Food, Drug, and Cosmetic
6 Act (21 U.S.C. 391 et seq.) is amended by adding at the
7 end the following:

8 **“SEC. 908. OFFICE OF MINORITY AFFAIRS.**

9 “(a) IN GENERAL.—Not later than 60 days after the
10 date of enactment of this section, the Secretary shall es-
11 tablish within the Office of the Commissioner of Food and
12 Drugs an Office of Minority Affairs (referred to in this
13 section as the ‘Office’).

14 “(b) DUTIES.—The Office shall be responsible for the
15 coordination and facilitation of activities of the Food and
16 Drug Administration to improve minority health and
17 healthcare and to reduce racial and ethnic disparities in
18 health and healthcare, which shall include—

19 “(1) promoting policies in the development and
20 review of medical products that reduce racial and
21 ethnic disparities in health and healthcare;

22 “(2) encouraging appropriate data collection,
23 analysis, and dissemination of racial and ethnic dif-
24 ferences using, at a minimum, the categories de-
25 scribed in the 1997 Office of Management and



1 Budget standards, in response to different therapies
2 in both adult and pediatric populations;

3 “(3) providing, in coordination with other ap-
4 propriate government agencies, education, training,
5 and support to increase participation of minority pa-
6 tients and physicians in clinical trials;

7 “(4) collecting and analyzing data using, at a
8 minimum, the categories described in the 1997 Of-
9 fice of Management and Budget standards, on the
10 number of participants from minority racial and eth-
11 nic backgrounds in clinical trials used to support
12 medical product approvals;

13 “(5) the identification of methods to reduce lan-
14 guage and literacy barriers; and

15 “(6) publishing an annual report about the ac-
16 tivities of the Food and Drug Administration per-
17 taining to minority health.

18 “(c) STAFF.—The staff of the Office shall include—

19 “(1) one or more individuals with expertise in
20 the design and conduct of clinical trials of drugs, bi-
21 ological products, and medical devices; and

22 “(2) one or more individuals with expertise in
23 therapeutic classes or disease states for which med-
24 ical evidence suggests a difference based on race or
25 ethnicity.



1 “(d) COORDINATION.—In carrying out its duties
2 under this section, the Office shall coordinate with—

3 “(1) the Office of Minority Health in the Office
4 of the Secretary of Health and Human Services;

5 “(2) the National Center for Minority Health
6 and Health Disparities in the National Institutes of
7 Health; and

8 “(3) the Office of Minority Health in the Cen-
9 ters for Disease Control and Prevention.

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
11 purpose of carrying out this section, there are authorized
12 to be appropriated such sums as may be necessary for
13 each of the fiscal years 2007 through 2012.”.

14 **SEC. 609. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
15 **RESPECT TO RACIAL AND ETHNIC BACK-**
16 **GROUND.**

17 (a) IN GENERAL.—Chapter V of the Federal Food,
18 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amend-
19 ed by adding after section 505B the following:

20 **“SEC. 505C. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
21 **RESPECT TO RACIAL AND ETHNIC BACK-**
22 **GROUND.**

23 “(a) PRE-APPROVAL STUDIES.—If there is evidence
24 that there may be a disparity on the basis of racial or



1 ethnic background as to the safety or effectiveness of a
2 drug, then—

3 “(1)(A) the investigations required under sec-
4 tion 505(b)(1)(A) shall include adequate and well-
5 controlled investigations of the disparity; or

6 “(B) the evidence required under section 351(a)
7 of the Public Health Service Act for approval of a
8 biologics license application for the drug shall in-
9 clude adequate and well-controlled investigations of
10 the disparity; and

11 “(2) if the investigations confirm that there is
12 a disparity, the labeling of the drug shall include ap-
13 propriate information about the disparity.

14 “(b) POST-MARKET STUDIES.—

15 “(1) IN GENERAL.—If there is evidence that
16 there may be a disparity on the basis of racial or
17 ethnic background as to the safety or effectiveness
18 of a drug for which there is an approved application
19 under section 505 or a license under section 351 of
20 the Public Health Service Act, the Secretary may by
21 order require the holder of the approved application
22 or license to conduct, by a date specified by the Sec-
23 retary, post-marketing studies to investigate the dis-
24 parity.



1 “(2) LABELING.—If the Secretary determines
2 that the post-market studies confirm that there is a
3 disparity described in paragraph (1), the labeling of
4 the drug shall include appropriate information about
5 the disparity.

6 “(3) STUDY DESIGN.—The Secretary may
7 specify all aspects of study design, including the
8 number of studies and study participants, in the
9 order requiring post-market studies of the drug.

10 “(4) MODIFICATIONS OF STUDY DESIGN.—The
11 Secretary may by order modify any aspect of the
12 study design as necessary after issuing an order
13 under paragraph (1).

14 “(5) STUDY RESULTS.—The results from stud-
15 ies required under paragraph (1) shall be submitted
16 to the Secretary as supplements to the drug applica-
17 tion or biological license application.

18 “(c) DISPARITY.—The term ‘evidence that there may
19 be a disparity on the basis of racial or ethnic background
20 for adult and pediatric populations as to the safety or ef-
21 fectiveness of a drug’ includes—

22 “(1) evidence that there is a disparity on the
23 basis of racial or ethnic background as to safety or
24 effectiveness of a drug in the same chemical class as
25 the drug;



1 “(2) evidence that there is a disparity on the
2 basis of racial or ethnic background in the way the
3 drug is metabolized; and

4 “(3) other evidence as the Secretary may deter-
5 mine.

6 “(d) APPLICATIONS UNDER SECTION 505(b)(2) AND
7 505(j).—

8 “(1) IN GENERAL.—A drug for which an appli-
9 cation has been submitted or approved under section
10 505(j) shall not be considered ineligible for approval
11 under that section or misbranded under section 502
12 on the basis that the labeling of the drug omits in-
13 formation relating to a disparity on the basis of ra-
14 cial or ethnic background as to the safety or effec-
15 tiveness of the drug, whether derived from investiga-
16 tions or studies required under this section or de-
17 rived from other sources, when the omitted informa-
18 tion is protected by patent or by exclusivity under
19 clause (iii) or (iv) of section 505(j)(5)(D).

20 “(2) LABELING.—Notwithstanding clauses (iii)
21 and (iv) of section 505(j)(5)(D), the Secretary may
22 require that the labeling of a drug approved under
23 section 505(j) that omits information relating to a
24 disparity on the basis of racial or ethnic background
25 as to the safety or effectiveness of the drug include



1 a statement of any appropriate contraindications,
2 warnings, or precautions related to the disparity
3 that the Secretary considers necessary.”.

4 (b) ENFORCEMENT.—Section 502 of the Federal
5 Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amend-
6 ed by adding at the end the following:

7 “(w)(1) If it is a drug and the holder of the approved
8 application under section 505 or license under section 351
9 of the Public Health Service Act for the drug has failed
10 to complete the investigations or studies, or comply with
11 any other requirement, of section 505C.”.

12 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
13 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h)
14 is amended by adding after “required” the following: “,
15 including supplements required under section 505C of the
16 Act”.

17 **SEC. 610. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

18 (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3 of the Civil Rights Commission Act of
19
20
21 1983 (42 U.S.C. 1975a) is amended—

22 (1) in paragraph (1)(B), by striking “and” at
23 the end;



1 (2) in paragraph (2), in the matter after and
2 below subparagraph (D), by striking the period and
3 inserting “; and”; and

4 (3) by adding at the end the following:

5 “(3) shall, with respect to activities carried out
6 in healthcare and correctional facilities toward the
7 goal of eliminating health disparities between the
8 general population and members of racial or ethnic
9 minority groups, coordinate such activities of—

10 “(A) the Office for Civil Rights within the
11 Department of Justice;

12 “(B) the Office of Justice Programs within
13 the Department of Justice;

14 “(C) the Office for Civil Rights within the
15 Department of Health and Human Services;
16 and

17 “(D) the Office of Minority Health within
18 the Department of Health and Human Services
19 (headed by the Deputy Assistant Secretary for
20 Minority Health).”.

21 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
22 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
23 1975c) is amended by striking the first sentence and in-
24 serting the following: “For the purpose of carrying out
25 this Act, there are authorized to be appropriated



1 \$30,000,000 for fiscal year 2007, and such sums as may
2 be necessary for each of the fiscal years 2008 through
3 2012.”.

4 **SEC. 610A. SENSE OF CONGRESS CONCERNING FULL FUND-**
5 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
6 **AND ETHNIC HEALTH DISPARITIES.**

7 (a) FINDINGS.—Congress makes the following find-
8 ings:

9 (1) The health status of the American populace
10 is declining and the United States currently ranks
11 below most industrialized nations in health status
12 measured by longevity, sickness, and mortality.

13 (2) Racial and ethnic minority populations tend
14 have the poorest health status and face substantial
15 cultural, social, and economic barriers to obtaining
16 quality healthcare.

17 (3) Efforts to improve minority health have
18 been limited by inadequate resources (funding, staff-
19 ing, and stewardship) and accountability.

20 (b) SENSE OF CONGRESS.—It is the sense of Con-
21 gress that—

22 (1) funding should be doubled by fiscal year
23 2007 for the National Center for Minority Health
24 Disparities, the Office of Civil Rights in the Depart-
25 ment of Health and Human Services, the National



1 Institute of Nursing Research, and the Office of Mi-
2 nority Health;

3 (2) adequate funding by fiscal year 2007, and
4 subsequent funding increases, should be provided for
5 health professions training programs, the Racial and
6 Ethnic Approaches to Community Health (REACH)
7 at the Center for Disease Control and Prevention,
8 the Minority HIV/AIDS Initiative, and the Excel-
9 lence Centers to Eliminate Ethnic/Racial Disparities
10 (EXCEED) Program at the Agency for Healthcare
11 Research and Quality;

12 (3) current and newly-created health disparity
13 elimination incentives, programs, agencies, and de-
14 partments under this Act (and the amendments
15 made by this Act) should receive adequate staffing
16 and funding by fiscal year 2007; and

17 (4) stewardship and accountability should be
18 provided by Congress and the President for health
19 disparity elimination.

20 **Subtitle B—Minority Health and**
21 **Genomics Commission**

22 **SEC. 611. SHORT TITLE.**

23 This subtitle may be cited as the “Minority Health
24 and Genomics Act of 2005”.



1 **SEC. 612. MINORITY HEALTH AND GENOMICS COMMISSION.**

2 (a) ESTABLISHMENT.—There is established a com-
3 mission to be known as the Minority Health and Genomics
4 Commission (in this subtitle referred to as the “Commis-
5 sion”).

6 (b) DUTIES.—

7 (1) STUDY.—The Commission shall conduct a
8 thorough study of, and develop recommendations on,
9 issues relating to genomic research as applied to mi-
10 nority groups and, under section 516, submit a re-
11 port to the appropriate committees of Congress that
12 recommends policies that the Commission finds will
13 ultimately improve healthcare and promote the elimi-
14 nation of health disparities.

15 (2) ISSUES.—The study under paragraph (1)
16 shall address specific issues and the needs of each
17 minority group described in subparagraph (A) in ad-
18 dition to issues involving genomic research that af-
19 fect the groups as a whole. In conducting such study
20 the Commission shall carry out the following:

21 (A) Establish standards in genomic re-
22 search and services that will promote the im-
23 provement of health and health-related services
24 for the following groups: American Indians and
25 Alaska Natives, African Americans, Asian



1 Americans, Hispanics, and Native Hawaiians
2 and other Pacific Islanders.

3 (B) Recommend minimum requirements
4 and standards for the equitable use of genetics
5 research in patient care and public health serv-
6 ices for racial and ethnic minority patients.

7 (C) Examine the accessibility, effective-
8 ness, availability, and cost efficiency of genomic
9 research, genetic testing, genetic counseling,
10 and genetic screening to minority populations.

11 (D) Determine and recommend procedures
12 and policies to address the need for cultural,
13 linguistic, and religious sensitivity training for
14 genetic counselors and researchers who work
15 with minority groups.

16 (E) Evaluate whether minority persons are
17 provided with informed consent that is cul-
18 turally and linguistically appropriate to allow a
19 fully informed decision about their healthcare,
20 availability of treatments or options, or partici-
21 pation in any clinical trial involving the collec-
22 tion of genetic material.

23 (F) Recommend how population sampling
24 studies of genetic information can be improved
25 to aid in the elimination of health disparities



1 and improve healthcare for minority commu-
2 nities.

3 (G) Examine how genetic material or in-
4 formation derived from individual minorities is
5 used the help minority groups with the use of
6 highly specific drug therapies.

7 (H) Identify the accessibility, effectiveness,
8 availability, privacy, and benefit of genetic data-
9 bases and depositories to minority communities.

10 (I) Identify the accessibility, effectiveness,
11 and affordability of reproductive technologies to
12 minority groups.

13 (J) Recommend an incentives program for
14 genomic researchers that will encourage the
15 study of disease and genetic ailments that dis-
16 proportionately affect minority communities.

17 **SEC. 613. REPORT.**

18 Not later than 2 years after the date of the enact-
19 ment of this Act, the Commission shall prepare and sub-
20 mit to the appropriate committees of Congress, the Presi-
21 dent, and the general public a report containing a detailed
22 statement of the findings and conclusions of the Commis-
23 sion with respect to matters described in section
24 512(b)(2), together with such recommendations as the



1 Commission considers appropriate that may be specific to
2 each minority group.

3 **SEC. 614. MEMBERSHIP.**

4 (a) NUMBER AND APPOINTMENT.—The Commission
5 shall be composed of 17 members to be appointed as fol-
6 lows:

7 (1) Four members shall be appointed by the
8 Speaker of the House of Representatives.

9 (2) Four members shall be appointed by the mi-
10 nority leader of the House of Representatives.

11 (3) Four members shall be appointed by the
12 majority leader of the Senate.

13 (4) Four members shall be appointed by the mi-
14 nority leader of the Senate.

15 (5) One member shall be appointed by the
16 President.

17 (b) PERSONS ELIGIBLE.—

18 (1) IN GENERAL.—The members of the Com-
19 mission shall be individuals who have knowledge or
20 expertise, whether by experience or training, in mat-
21 ters to be studied by the Commission. The members
22 may be from the public or private sector, and may
23 include employees of the Federal Government or of
24 State, territory, tribal, or local governments, mem-
25 bers of academia, legal scholars and practitioners,



1 tribal leaders, representatives of nonprofit organiza-
2 tions, or other interested individuals who dem-
3 onstrate a dedication to the use of genomics to im-
4 prove minority healthcare and the elimination of
5 health disparities among minorities.

6 (2) DIVERSITY.—It is the intent of Congress
7 that individuals appointed to the Commission rep-
8 resent diverse interests, ethnicities, various profes-
9 sional backgrounds, and are from different regions
10 of the United States.

11 (c) CONSULTATION AND APPOINTMENT.—

12 (1) IN GENERAL.—The President, Speaker of
13 the House of Representatives, minority leader of the
14 House of Representatives, majority leader of the
15 Senate, and minority leader of the Senate shall con-
16 sult among themselves before appointing the mem-
17 bers of the Commission in order to achieve, to the
18 maximum extent practicable, fair and equitable rep-
19 resentation of various points of view with respect to
20 matters studied by the Commission.

21 (2) DATE OF APPOINTMENT.—The appoint-
22 ments of the members of the Commission shall be
23 made not later than 90 days after the date of enact-
24 ment of this Act.

25 (d) TERMS.—



1 (1) IN GENERAL.—Each member of the Com-
2 mission shall be appointed for the life of the Com-
3 mission.

4 (2) VACANCIES.—A vacancy in the Commission
5 shall be filled in the manner in which the original
6 appointment was made.

7 (e) BASIC PAY.—Members of the Commission shall
8 serve without pay.

9 (f) TRAVEL EXPENSES.—Each member of the Com-
10 mission shall receive travel expenses, including per diem
11 in lieu of subsistence, in accordance with applicable provi-
12 sions under subchapter I of chapter 57 of title 5, United
13 States Code.

14 (g) CHAIRPERSON AND VICE CHAIRPERSON.—The
15 members of the Commission shall elect a Chairperson and
16 Vice Chairperson of the Commission from among the
17 members.

18 (h) MEETINGS.—

19 (1) IN GENERAL.—The Commission shall meet
20 at the call of the Chairperson or a majority of its
21 members.

22 (2) INITIAL MEETING.—Not later than 30 days
23 after the date on which all members of the Commis-
24 sion have been appointed, the Commission shall hold
25 its first meeting.



1 **SEC. 615. POWERS OF COMMISSION.**

2 (a) HEARINGS AND SESSIONS.—The Commission
3 may, for the purpose of carrying out this subtitle, hold
4 hearings, sit and act at times and places, take testimony,
5 and receive evidence as the Commission considers appro-
6 priate to carry out this subtitle.

7 (b) POWERS OF MEMBERS AND AGENTS.—Any mem-
8 ber or agent of the Commission may, if authorized by the
9 Commission, take any action that the Commission is au-
10 thorized to take by this section.

11 (c) OBTAINING OFFICIAL DATA.—Notwithstanding
12 sections 552 and 552a of title 5, United States Code, the
13 Commission may secure directly from any department or
14 agency of the United States information necessary to en-
15 able it to carry out this subtitle. Upon request of the Com-
16 mission, the head of that department or agency shall fur-
17 nish that information to the Commission.

18 (d) POSTAL SERVICES.—The Commission may use
19 the United States mails in the same manner and under
20 the same conditions as other departments and agencies of
21 the United States.

22 (e) WEBSITE.—For purposes of conducting the study
23 under section 512(b)(1), the Commission shall establish
24 and maintain a website to facilitate public comment and
25 participation.



1 (f) STAFF OF FEDERAL AGENCIES.—Upon request
2 of the Commission, the head of any Federal department
3 or agency may detail, on a nonreimbursable basis, any of
4 the personnel of that department or agency to the Com-
5 mission to assist it in carrying out its duties under this
6 subtitle.

7 (g) ADMINISTRATIVE SUPPORT SERVICES.—Upon
8 the request of the Commission, the Administrator of Gen-
9 eral Services may provide to the Commission, on a non-
10 reimbursable basis, the administrative support services
11 necessary for the Commission to carry out its responsibil-
12 ities under this subtitle.

13 **SEC. 616. TERMINATION.**

14 The Commission shall terminate 1 year after submit-
15 ting its final report pursuant to section 513.

16 **Subtitle C—Improving**
17 **Environmental Justice**

18 **SEC. 621. DEFINITIONS.**

19 For purposes of this subtitle:

20 (1) ENVIRONMENTAL JUSTICE.—

21 (A) IN GENERAL.—The term “environ-
22 mental justice” means the fair treatment of
23 people of all races, cultures, and socioeconomic
24 groups with respect to the development, adop-
25 tion, implementation, and enforcement of laws,



1 regulations, and policies affecting the environ-
2 ment.

3 (B) FAIR TREATMENT.—The term “fair
4 treatment” means policies and practices that
5 will minimize the likelihood that a minority,
6 low-income, or Native American community will
7 bear a disproportionate share of the adverse en-
8 vironmental consequences, or be denied reason-
9 able access to the environmental benefits, re-
10 sulting from implementation of a Federal pro-
11 gram or policy.

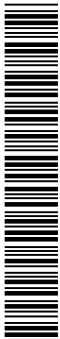
12 (2) FEDERAL AGENCY.—The term “Federal
13 agency” means—

14 (A) each Federal entity represented on the
15 Working Group;

16 (B) any other entity that conducts any
17 Federal program or activity that substantially
18 affects human health or the environment; and

19 (C) each Federal agency that implements
20 any program, policy, or activity applicable to
21 Native Americans.

22 (3) WORKING GROUP.—The term “Working
23 Group” means the interagency working group estab-
24 lished by section 413.



1 (4) ADVISORY COMMITTEE.—The term “the Ad-
2 visory Committee” means the advisory committee es-
3 tablished by section 415.

4 **SEC. 622. ENVIRONMENTAL JUSTICE RESPONSIBILITIES OF**
5 **FEDERAL AGENCIES.**

6 (a) ENVIRONMENTAL JUSTICE MISSION.—To the
7 greatest extent practicable, the head of each Federal agen-
8 cy shall make achieving environmental justice part of its
9 mission by identifying and addressing, as appropriate, dis-
10 proportionately high and adverse human health or envi-
11 ronmental effects of its programs, policies, and activities
12 on minority and low-income populations in the United
13 States and its territories and possessions, including the
14 District of Columbia, the Commonwealth of Puerto Rico,
15 Virgin Islands, Guam, and the Commonwealth of the Mar-
16 iana Islands.

17 (b) NONDISCRIMINATION.—Each Federal agency
18 shall conduct its programs, policies, and activities in a
19 manner that ensures that such programs, policies, and ac-
20 tivities do not have the effect of excluding any person or
21 group from participation in, denying any person or group
22 the benefits of, or subjecting any person or group to dis-
23 crimination under, such programs, policies, and activities,
24 because of race, color, national origin, or income.



1 **SEC. 623. INTERAGENCY ENVIRONMENTAL JUSTICE WORK-**
2 **ING GROUP.**

3 (a) CREATION AND COMPOSITION.—There is hereby
4 established the Interagency Working Group on Environ-
5 mental Justice, comprising the heads of the following exec-
6 utive agencies and offices, or their designees:

7 (1) The Department of Defense.

8 (2) The Department of Health and Human
9 Services.

10 (3) The Department of Housing and Urban De-
11 velopment.

12 (4) The Department of Homeland Security.

13 (5) The Department of Labor.

14 (6) The Department of Agriculture.

15 (7) The Department of Transportation.

16 (8) The Department of Justice;

17 (9) The Department of the Interior.

18 (10) The Department of Commerce.

19 (11) The Department of Energy.

20 (12) The Environmental Protection Agency.

21 (13) The Office of Management and Budget.

22 (14) Any other official of the United States
23 that the President may designate.

24 (b) FUNCTIONS.—The Working Group shall—

25 (1) provide guidance to Federal agencies on cri-
26 teria for identifying disproportionately high and ad-



1 verse human health or environmental effects on mi-
2 nority, low-income, and Native American popu-
3 lations;

4 (2) coordinate with, provide guidance to, and
5 serve as a clearinghouse for, each Federal agency as
6 it develops or revises an environmental justice strat-
7 egy as required by this subtitle, in order to ensure
8 that the administration, interpretation and enforce-
9 ment of programs, activities, and policies are under-
10 taken in a consistent manner;

11 (3) assist in coordinating research by, and stim-
12 ulating cooperation among, the Environmental Pro-
13 tection Agency, the Department of Health and
14 Human Services, the Department of Housing and
15 Urban Development, and other Federal agencies
16 conducting research or other activities in accordance
17 with section 7;

18 (4) assist in coordinating data collection, main-
19 tenance, and analysis required by this subtitle;

20 (5) examine existing data and studies on envi-
21 ronmental justice;

22 (6) hold public meetings and otherwise solicit
23 public participation and consider complaints as re-
24 quired under subsection (c);



1 (7) develop interagency model projects on envi-
2 ronmental justice that evidence cooperation among
3 Federal agencies; and

4 (8) in coordination with the Department of the
5 Interior and after consultation with tribal leaders,
6 coordinate steps to be taken pursuant to this subtitle
7 that affect or involve federally-recognized Indian
8 Tribes.

9 (c) PUBLIC PARTICIPATION.—The Working Group
10 shall—

11 (1) hold public meetings and otherwise solicit
12 public participation, as appropriate, for the purpose
13 of fact-finding with regard to implementation of this
14 subtitle, and prepare for public review a summary of
15 the comments and recommendations provided; and

16 (2) receive, consider, and in appropriate in-
17 stances conduct inquiries concerning complaints re-
18 garding environmental justice and the implementa-
19 tion of this subtitle by Federal agencies.

20 (d) ANNUAL REPORTS.—

21 (1) IN GENERAL.—Each fiscal year following
22 enactment of this Act, the Working Group shall sub-
23 mit to the President, through the Office of the Dep-
24 uty Assistant to the President for Environmental
25 Policy and the Office of the Assistant to the Presi-



1 dent for Domestic Policy, a report that describes the
2 implementation of this subtitle, including, but not
3 limited to, a report of the final environmental justice
4 strategies described in section 6 of this subtitle and
5 annual progress made in implementing those strate-
6 gies.

7 (2) COPY OF REPORT.—The President shall
8 transmit to the Speaker of the House of Representa-
9 tives and the President of the Senate a copy of each
10 report submitted to the President pursuant to para-
11 graph (1).

12 (e) CONFORMING CHANGE.—The Interagency Work-
13 ing Group on Environmental Justice established under
14 Executive Order No. 12898, dated February 11, 1994, is
15 abolished.

16 **SEC. 624. FEDERAL AGENCY STRATEGIES.**

17 (a) AGENCY-WIDE STRATEGIES.—Each Federal
18 agency shall develop an agency-wide environmental justice
19 strategy that identifies and addresses disproportionately
20 high and adverse human health or environmental effects
21 or disproportionately low benefits of its programs, policies,
22 and activities with respect to minority, low-income, and
23 Native American populations.

24 (b) REVISIONS.—Each strategy developed pursuant
25 to subsection (a) shall identify programs, policies, plan-



1 ning, and public participation processes, rulemaking, and
2 enforcement activities related to human health or the envi-
3 ronment that should be revised to—

4 (1) promote enforcement of all health and envi-
5 ronmental statutes in areas with minority, low-in-
6 come, or Native American populations;

7 (2) ensure greater public participation;

8 (3) improve research and data collection relat-
9 ing to the health of and environment of minority,
10 low-income, and Native American populations; and

11 (4) identify differential patterns of use of nat-
12 ural resources among minority, low-income, and Na-
13 tive American populations.

14 (c) TIMETABLES.—Each strategy developed pursuant
15 to subsection (a) shall include, where appropriate, a time-
16 table for undertaking revisions identified pursuant to sub-
17 section (b).

18 **SEC. 625. FEDERAL ENVIRONMENTAL JUSTICE ADVISORY**
19 **COMMITTEE.**

20 (a) ESTABLISHMENT.—There is established a com-
21 mittee to be known as the “Federal Environmental Justice
22 Advisory Committee”.

23 (b) DUTIES.—The Advisory Committee shall provide
24 independent advice and recommendations to the Environ-
25 mental Protection Agency and the Working Group on



1 areas relating to environmental justice, which may include
2 any of the following:

3 (1) Advice on Federal agencies' framework de-
4 velopment for integrating socioeconomic programs
5 into strategic planning, annual planning, and man-
6 agement accountability for achieving environmental
7 justice results agency-wide.

8 (2) Advice on measuring and evaluating agen-
9 cies' progress, quality, and adequacy in planning, de-
10 veloping, and implementing environmental justice
11 strategies, projects, and programs.

12 (3) Advice on agencies' existing and future in-
13 formation management systems, technologies, and
14 data collection, and the conduct of analyses that
15 support and strengthen environmental justice pro-
16 grams in administrative and scientific areas.

17 (4) Advice to help develop, facilitate, and con-
18 duct reviews of the direction, criteria, scope, and
19 adequacy of the Federal agencies' scientific research
20 and demonstration projects relating to environ-
21 mental justice.

22 (5) Advice for improving how the Environ-
23 mental Protection Agency and others participate, co-
24 operate, and communicate within that agency and
25 between other Federal agencies, State or local gov-



1 ernments, federally recognized Tribes, environmental
2 justice leaders, interest groups, and the public.

3 (6) Advice regarding the Environmental Protec-
4 tion Agency's administration of grant programs re-
5 lating to environmental justice assistance (not to in-
6 clude the review or recommendations of individual
7 grant proposals or awards).

8 (7) Advice regarding agencies' awareness, edu-
9 cation, training, and other outreach activities involv-
10 ing environmental justice.

11 (c) ADVISORY COMMITTEE.—The Advisory Com-
12 mittee shall be considered an advisory committee within
13 the meaning of the Federal Advisory Committee Act (5
14 U.S.C. App.).

15 (d) MEMBERSHIP.—

16 (1) IN GENERAL.—The Advisory Committee
17 shall be composed of 21 members to be appointed in
18 accordance with paragraph (2). Members shall in-
19 clude representatives of—

20 (A) community-based groups;

21 (B) industry and business;

22 (C) academic and educational institutions;

23 (D) minority health organizations;

24 (E) State and local governments, federally
25 recognized tribes, and indigenous groups; and



1 (F) nongovernmental and environmental
2 groups.

3 (2) APPOINTMENTS.—Of the members of the
4 Advisory Committee—

5 (A) five members shall be appointed by the
6 majority leader of the Senate;

7 (B) five members shall be appointed by the
8 minority leader of the Senate;

9 (C) five members shall be appointed by the
10 Speaker of the House of Representatives;

11 (D) five members shall be appointed by the
12 minority leader of the House of Representa-
13 tives; and

14 (E) one member to be appointed by the
15 President.

16 (e) MEETINGS.—The Advisory Committee shall meet
17 at least twice annually. Meetings shall occur as needed and
18 approved by the Director of the Office of Environmental
19 Justice of the Environmental Protection Agency, who shall
20 serve as the officer required to be appointed under section
21 10(e) of the Federal Advisory Committee Act (5 U.S.C.
22 App.) with respect to the Committee (in this subsection
23 referred to as the “Designated Federal Officer”). The Ad-
24 ministrator of the Environmental Protection Agency may
25 pay travel and per diem expenses of members of the Advi-



1 sory Committee when determined necessary and appro-
2 priate. The Designated Federal Officer or a designee of
3 such Officer shall be present at all meetings, and each
4 meeting will be conducted in accordance with an agenda
5 approved in advance by such Officer. The Designated Fed-
6 eral Officer may adjourn any meeting when the Des-
7 ignated Federal Officer determines it is in the public inter-
8 est to do so. As required by the Federal Advisory Com-
9 mittee Act, meetings of the Advisory Committee shall be
10 open to the public unless the President determines that
11 a meeting or a portion of a meeting may be closed to the
12 public in accordance with subsection (c) of section 552b
13 of title 5, United States Code. Unless a meeting or portion
14 thereof is closed to the public, the Designated Federal Of-
15 ficer shall provide an opportunity for interested persons
16 to file comments before or after such meeting or to make
17 statements to the extent that time permits.

18 (f) DURATION.—The Advisory Committee shall re-
19 main in existence until otherwise provided by law.

20 **SEC. 626. HUMAN HEALTH AND ENVIRONMENTAL RE-**
21 **SEARCH, DATA COLLECTION AND ANALYSIS.**

22 (a) DISPROPORTIONATE IMPACT.—To the extent per-
23 mitted by other applicable law, including section 552a of
24 title 5, United States Code, popularly known as the Pri-
25 vacy Act of 1974, the Administrator of the Environmental



1 Protection Agency, or the head of such other Federal
2 agency as the President may direct, shall collect, maintain,
3 and analyze information assessing and comparing environ-
4 mental and human health risks borne by populations iden-
5 tified by race, national origin, or income. To the extent
6 practical and appropriate, Federal agencies shall use this
7 information to determine whether their programs, policies,
8 and activities have disproportionately high and adverse
9 human health or environmental effects on, or
10 disproportionately low benefits for, minority, low-income,
11 and Native American populations.

12 (b) INFORMATION RELATED TO NON-FEDERAL FA-
13 CILITIES.—In connection with the development and imple-
14 mentation of agency strategies in section 4, the Adminis-
15 trator of the Environmental Protection Agency, or the
16 head of such other Federal agency as the President may
17 direct, shall collect, maintain, and analyze information on
18 the race, national origin, and income level, and other read-
19 ily accessible and appropriate information, for areas sur-
20 rounding facilities or sites expected to have a substantial
21 environmental, human health, or economic effect on the
22 surrounding populations, if such facilities or sites become
23 the subject of a substantial Federal environmental admin-
24 istrative or judicial action.



1 (c) IMPACT FROM FEDERAL FACILITIES.—The Ad-
2 ministrators of the Environmental Protection Agency, or
3 the head of such other Federal agency as the President
4 may direct, shall collect, maintain, and analyze informa-
5 tion on the race, national origin, and income level, and
6 other readily accessible and appropriate information, for
7 areas surrounding Federal facilities that are—

8 (1) subject to the reporting requirements under
9 the Emergency Planning and Community Right-to-
10 Know Act (42 U.S.C. 11001 et seq.) as mandated
11 in Executive Order No. 12856; and

12 (2) expected to have a substantial environ-
13 mental, human health, or economic effect on sur-
14 rounding populations.

15 (d) INFORMATION SHARING.—

16 (1) IN GENERAL.—In carrying out the respon-
17 sibilities in this section, each Federal agency, to the
18 extent practicable and appropriate, shall share infor-
19 mation and eliminate unnecessary duplication of ef-
20 forts through the use of existing data systems and
21 cooperative agreements among Federal agencies and
22 with State, local, and tribal governments.

23 (2) PUBLIC AVAILABILITY.—Except as prohib-
24 ited by other applicable law, information collected or



1 maintained pursuant to this section shall be made
2 available to the public.

3 (e) PUBLIC COMMENT.—Federal agencies shall pro-
4 vide minority, low-income, and Native American popu-
5 lations the opportunity to participate in the development,
6 design, and conduct of activities undertaken pursuant to
7 this section.

8 **TITLE VII—STRENGTHENING**
9 **HEALTH INSTITUTIONS THAT**
10 **PROVIDE HEALTHCARE TO**
11 **MINORITY POPULATIONS**

12 **Subtitle A—General Provisions**

13 **SEC. 701. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

14 **ACT.**

15 Title XXIX of the Public Health Service Act, as
16 amended by titles II, III, V, and VI of this Act, is further
17 amended by adding at the end the following:



1 **“Subtitle E—Strengthening Health**
2 **Institutions That Provide**
3 **Healthcare to Minority Popu-**
4 **lations**

5 **“CHAPTER 1—GENERAL PROGRAMS**

6 **“SEC. 2951. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
7 **INITIATIVES.**

8 “(a) IN GENERAL.—The Secretary, in collaboration
9 with the Administrator of the Health Resources and Serv-
10 ices Administration, the Director of the Agency for
11 Healthcare Research and Quality, and the Administrator
12 of the Centers for Medicare and Medicaid Services, shall
13 award grants to eligible entities for the conduct of dem-
14 onstration projects to improve the quality of and access
15 to healthcare.

16 “(b) ELIGIBILITY.—To be eligible to receive a grant
17 under subsection (a), an entity shall—

18 “(1) be a health center, hospital, health plan,
19 health system, community clinic, or other health en-
20 tity determined appropriate by the Secretary—

21 “(A) that, by legal mandate or explicitly
22 adopted mission, provides patients with access
23 to services regardless of their ability to pay;

24 “(B) that provides care or treatment for a
25 substantial number of patients who are unin-



1 sured, are receiving assistance under a State
2 program under title XIX of the Social Security
3 Act, or are members of vulnerable populations,
4 as determined by the Secretary; and

5 “(C)(i) with respect to which, not less than
6 50 percent of the entity’s patient population is
7 made up of racial and ethnic minorities; or

8 “(ii) that—

9 “(I) serves a disproportionate percent-
10 age of local, minority racial and ethnic pa-
11 tients, or that has a patient population, at
12 least 50 percent of which is limited English
13 proficient; and

14 “(II) provides an assurance that
15 amounts received under the grant will be
16 used only to support quality improvement
17 activities in the racial and ethnic popu-
18 lation served; and

19 “(2) prepare and submit to the Secretary an
20 application at such time, in such manner, and con-
21 taining such information as the Secretary may re-
22 quire.

23 “(c) PRIORITY.—In awarding grants under sub-
24 section (a), the Secretary shall give priority to applicants
25 under subsection (b)(2) that—



1 “(1) demonstrate an intent to operate as part
2 of a healthcare partnership, network, collaborative,
3 coalition, or alliance where each member entity con-
4 tributes to the design, implementation, and evalua-
5 tion of the proposed intervention; or

6 “(2) intend to use funds to carry out system-
7 wide changes with respect to healthcare quality im-
8 provement, including—

9 “(A) improved systems for data collection
10 and reporting;

11 “(B) innovative collaborative or similar
12 processes;

13 “(C) group programs with behavioral or
14 self-management interventions;

15 “(D) case management services;

16 “(E) physician or patient reminder sys-
17 tems;

18 “(F) educational interventions; or

19 “(G) other activities determined appro-
20 priate by the Secretary.

21 “(d) USE OF FUNDS.—An entity shall use amounts
22 received under a grant under subsection (a) to support
23 the implementation and evaluation of healthcare quality
24 improvement activities or minority health and healthcare
25 disparity reduction activities that include—



1 “(1) with respect to healthcare systems, activi-
2 ties relating to improving—

3 “(A) patient safety;

4 “(B) timeliness of care;

5 “(C) effectiveness of care;

6 “(D) efficiency of care; and

7 “(E) patient centeredness; and

8 “(2) with respect to patients, activities relating
9 to—

10 “(A) staying healthy;

11 “(B) getting well;

12 “(C) living with illness or disability; and

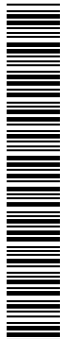
13 “(D) coping with end of life issues.

14 “(e) COMMON DATA SYSTEMS.—The Secretary shall
15 provide financial and other technical assistance to grant-
16 ees under this section for the development of common data
17 systems.

18 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section,
20 such sums as may be necessary for each of fiscal years
21 2007 through 2012.

22 **“SEC. 2951A. CENTERS OF EXCELLENCE.**

23 “(a) IN GENERAL.—The Secretary, acting through
24 the Administrator of the Health Resources and Services
25 Administration, shall designate centers of excellence at



1 public hospitals, and other health systems serving large
2 numbers of minority patients, that—

3 “(1) meet the requirements of section
4 2971(b)(1);

5 “(2) demonstrate excellence in providing care to
6 minority populations; and

7 “(3) demonstrate excellence in reducing dispari-
8 ties in health and healthcare.

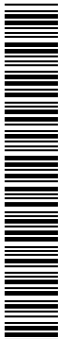
9 “(b) REQUIREMENTS.—A hospital or health system
10 that serves as a Center of Excellence under subsection (a)
11 shall—

12 “(1) design, implement, and evaluate programs
13 and policies relating to the delivery of care in ra-
14 cially, ethnically, and linguistically diverse popu-
15 lations;

16 “(2) provide training and technical assistance
17 to other hospitals and health systems relating to the
18 provision of quality healthcare to minority popu-
19 lations; and

20 “(3) develop activities for graduate or con-
21 tinuing medical education that institutionalize a
22 focus on cultural competence training for health care
23 providers.

24 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
25 is authorized to be appropriated to carry out this section,



1 such sums as may be necessary for each of fiscal years
2 2007 through 2012.

3 **“SEC. 2952B. CONSULTATION, CONSTRUCTION AND REN-**
4 **OVATION OF AMERICAN INDIAN AND ALASKA**
5 **NATIVE FACILITIES; REPORTS.**

6 “(a) CONSULTATION.—Prior to the expenditure of, or
7 the making of any firm commitment to expend, any funds
8 appropriated for the planning, design, construction, or
9 renovation of facilities pursuant to the Act of November
10 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder
11 Act), the Secretary, acting through the Service, shall—

12 “(1) consult with any Indian tribe that would
13 be significantly affected by such expenditure for the
14 purpose of determining and, whenever practicable,
15 honoring tribal preferences concerning size, location,
16 type, and other characteristics of any facility on
17 which such expenditure is to be made; and

18 “(2) ensure, whenever practicable, that such fa-
19 cility meets the construction standards of any na-
20 tionally recognized accrediting body by not later
21 than 1 year after the date on which the construction
22 or renovation of such facility is completed.

23 “(b) CLOSURE OF FACILITIES.—

24 “(1) IN GENERAL.—Notwithstanding any provi-
25 sion of law other than this subsection, no Service



1 hospital or outpatient healthcare facility or any inpa-
2 tient service or special care facility operated by the
3 Service, may be closed if the Secretary has not sub-
4 mitted to the Congress at least 1 year prior to the
5 date such proposed closure an evaluation of the im-
6 pact of such proposed closure which specifies, in ad-
7 dition to other considerations—

8 “(A) the accessibility of alternative
9 healthcare resources for the population served
10 by such hospital or facility;

11 “(B) the cost effectiveness of such closure;

12 “(C) the quality of healthcare to be pro-
13 vided to the population served by such hospital
14 or facility after such closure;

15 “(D) the availability of contract healthcare
16 funds to maintain existing levels of service;

17 “(E) the views of the Indian tribes served
18 by such hospital or facility concerning such clo-
19 sure;

20 “(F) the level of utilization of such hos-
21 pital or facility by all eligible Indians; and

22 “(G) the distance between such hospital or
23 facility and the nearest operating Service hos-
24 pital.



1 “(2) TEMPORARY CLOSURE.—Paragraph (1)
2 shall not apply to any temporary closure of a facility
3 or of any portion of a facility if such closure is nec-
4 essary for medical, environmental, or safety reasons.

5 “(c) PRIORITY SYSTEM.—

6 “(1) ESTABLISHMENT.—The Secretary shall es-
7 tablish a healthcare facility priority system, that
8 shall—

9 “(A) be developed with Indian tribes and
10 tribal organizations through negotiated rule-
11 making;

12 “(B) give the needs of Indian tribes the
13 highest priority, with additional priority being
14 given to those service areas where the health
15 status of Indians within the area, as measured
16 by life expectancy based upon the most recent
17 data available, is significantly lower than the
18 average health status for Indians in all service
19 areas; and

20 “(C) at a minimum, include the lists re-
21 quired in paragraph (2)(B) and the method-
22 ology required in paragraph (2)(E);

23 except that the priority of any project established
24 under the construction priority system in effect on
25 the date of this Act shall not be affected by any



1 change in the construction priority system taking
2 place thereafter if the project was identified as one
3 of the top 10 priority inpatient projects or one of the
4 top 10 outpatient projects in the Indian Health
5 Service budget justification for fiscal year 2006, or
6 if the project had completed both Phase I and Phase
7 II of the construction priority system in effect on
8 the date of this title.

9 “(2) REPORT.—The Secretary shall submit to
10 the President and Congress a report that includes—

11 “(A) a description of the healthcare facility
12 priority system of the Service, as established
13 under paragraph (1);

14 “(B) healthcare facility lists, including—

15 “(i) the total healthcare facility plan-
16 ning, design, construction and renovation
17 needs for Indians;

18 “(ii) the 10 top-priority inpatient care
19 facilities;

20 “(iii) the 10 top-priority outpatient
21 care facilities;

22 “(iv) the 10 top-priority specialized
23 care facilities (such as long-term care and
24 alcohol and drug abuse treatment); and



1 “(v) any staff quarters associated
2 with such prioritized facilities;

3 “(C) the justification for the order of pri-
4 ority among facilities;

5 “(D) the projected cost of the projects in-
6 volved; and

7 “(E) the methodology adopted by the Serv-
8 ice in establishing priorities under its healthcare
9 facility priority system.

10 “(3) CONSULTATION.—In preparing each report
11 required under paragraph (2) (other than the initial
12 report) the Secretary shall annually—

13 “(A) consult with, and obtain information
14 on all healthcare facilities needs from, Indian
15 tribes and tribal organizations including those
16 tribes or tribal organizations operating health
17 programs or facilities under any funding agree-
18 ment entered into with the Service under the
19 Indian Self-Determination and Education As-
20 sistance Act; and

21 “(B) review the total unmet needs of all
22 tribes and tribal organizations for healthcare
23 facilities (including staff quarters), including
24 needs for renovation and expansion of existing
25 facilities.



1 “(4) CRITERIA.—For purposes of this sub-
2 section, the Secretary shall, in evaluating the needs
3 of facilities operated under any funding agreement
4 entered into with the Service under the Indian Self-
5 Determination and Education Assistance Act, use
6 the same criteria that the Secretary uses in evalu-
7 ating the needs of facilities operated directly by the
8 Service.

9 “(5) EQUITABLE INTEGRATION.—The Secretary
10 shall ensure that the planning, design, construction,
11 and renovation needs of Service and non-Service fa-
12 cilities, operated under funding agreements in ac-
13 cordance with the Indian Self-Determination and
14 Education Assistance Act are fully and equitably in-
15 tegrated into the healthcare facility priority system.

16 “(d) REVIEW OF NEED FOR FACILITIES.—

17 “(1) REPORT.—Beginning in 2007, the Sec-
18 retary shall annually submit to the President and
19 Congress a report which sets forth the needs of the
20 Service and all Indian tribes and tribal organiza-
21 tions, including urban Indian organizations, for in-
22 patient, outpatient and specialized care facilities, in-
23 cluding the needs for renovation and expansion of
24 existing facilities.



1 “(2) CONSULTATION.—In preparing each report
2 required under paragraph (1) (other than the initial
3 report), the Secretary shall consult with Indian
4 tribes and tribal organizations including those tribes
5 or tribal organizations operating health programs or
6 facilities under any funding agreement entered into
7 with the Service under the Indian Self-Determina-
8 tion and Education Assistance Act, and with urban
9 Indian organizations.

10 “(3) CRITERIA.—For purposes of this sub-
11 section, the Secretary shall, in evaluating the needs
12 of facilities operated under any funding agreement
13 entered into with the Service under the Indian Self-
14 Determination and Education Assistance Act, use
15 the same criteria that the Secretary uses in evalu-
16 ating the needs of facilities operated directly by the
17 Service.

18 “(4) EQUITABLE INTEGRATION.—The Secretary
19 shall ensure that the planning, design, construction,
20 and renovation needs of facilities operated under
21 funding agreements, in accordance with the Indian
22 Self-Determination and Education Assistance Act,
23 are fully and equitably integrated into the develop-
24 ment of the health facility priority system.



1 “(5) ANNUAL NOMINATIONS.—Each year the
2 Secretary shall provide an opportunity for the nomi-
3 nation of planning, design, and construction projects
4 by the Service and all Indian tribes and tribal orga-
5 nizations for consideration under the healthcare fa-
6 cility priority system.

7 “(e) INCLUSION OF CERTAIN PROGRAMS.—All funds
8 appropriated under the Act of November 2, 1921 (25
9 U.S.C. 13), for the planning, design, construction, or ren-
10 ovation of health facilities for the benefit of an Indian
11 tribe or tribes shall be subject to the provisions of section
12 102 of the Indian Self-Determination and Education As-
13 sistance Act.

14 “(f) INNOVATIVE APPROACHES.—The Secretary shall
15 consult and cooperate with Indian tribes, tribal organiza-
16 tions and urban Indian organizations in developing inno-
17 vative approaches to address all or part of the total unmet
18 need for construction of health facilities, including those
19 provided for in other sections of this title and other ap-
20 proaches.

21 “(g) LOCATION OF FACILITIES.—

22 “(1) PRIORITY.—The Bureau of Indian Affairs
23 and the Service shall, in all matters involving the re-
24 organization or development of Service facilities, or
25 in the establishment of related employment projects



1 to address unemployment conditions in economically
2 depressed areas, give priority to locating such facili-
3 ties and projects on Indian lands if requested by the
4 Indian owner and the Indian tribe with jurisdiction
5 over such lands or other lands owned or leased by
6 the Indian tribe or tribal organization so long as pri-
7 ority is given to Indian land owned by an Indian
8 tribe or tribes.

9 “(2) DEFINITION.—In this subsection, the term
10 ‘Indian lands’ means—

11 “(A) all lands within the exterior bound-
12 aries of any Indian reservation;

13 “(B) any lands title to which is held in
14 trust by the United States for the benefit of
15 any Indian tribe or individual Indian, or held by
16 any Indian tribe or individual Indian subject to
17 restriction by the United States against alien-
18 ation and over which an Indian tribe exercises
19 governmental power; and

20 “(C) all lands in Alaska owned by any
21 Alaska Native village, or any village or regional
22 corporation under the Alaska Native Claims
23 Settlement Act, or any land allotted to any
24 Alaska Native.



1 “(h) DEFINITIONS.—For purposes of this section, the
2 definitions contained in section 4 of the Indian Health
3 Care Improvement Act shall apply.

4 **“SEC. 2951C. RECONSTRUCTION AND IMPROVEMENT**
5 **GRANTS FOR PUBLIC HEALTH CARE FACILI-**
6 **TIES SERVING PACIFIC ISLANDERS AND THE**
7 **INSULAR AREAS.**

8 “(a) IN GENERAL.—The Secretary shall provide di-
9 rect financial assistance to designated healthcare providers
10 and community health centers in American Samoa, Guam,
11 the Commonwealth of the Northern Mariana Islands, the
12 United States Virgin Islands, Puerto Rico, and Hawaii for
13 the purposes of reconstructing and improving health care
14 facilities and services.

15 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
16 nancial assistance under subsection (a), an entity shall be
17 a public health facility or community health center located
18 in American Samoa, Guam, or the Commonwealth of the
19 Northern Mariana Islands, the United States Virgin Is-
20 lands, Puerto Rico, and Hawaii that—

21 “(1) is owned or operated by—

22 “(A) the government of American Samoa,
23 Guam, or the Commonwealth of the Northern
24 Mariana Islands, the United States Virgin Is-



1 lands, Puerto Rico, and Hawaii or a unit of
2 local government; or

3 “(B) a nonprofit organization; and

4 “(2)(A) provides care or treatment for a sub-
5 stantial number of patients who are uninsured, re-
6 ceiving assistance under a State program under a
7 title XVIII of the Social Security Act, or a State
8 program under title XIX of such Act, or who are
9 members of a vulnerable population, as determined
10 by the Secretary; or

11 “(B) serves a disproportionate percentage of
12 local, minority racial and ethnic patients.

13 “(c) REPORT.—Not later than 180 days after the
14 date of enactment of this title and annually thereafter, the
15 Secretary shall submit to the Congress and the President
16 a report that includes an assessment of health resources
17 and facilities serving populations in American Samoa,
18 Guam, and the Commonwealth of the Northern Mariana
19 Islands, the United States Virgin Islands, Puerto Rico,
20 and Hawaii. In preparing such report, the Secretary
21 shall—

22 “(1) consult with and obtain information on all
23 healthcare facilities needs from the entities described
24 in subsection (b); and



1 “(2) include all amounts of Federal assistance
2 received by each entity in the preceding fiscal year;

3 “(3) review the total unmet needs of each juris-
4 diction for healthcare facilities, including needs for
5 renovation and expansion of existing facilities; and

6 “(4) include a strategic plan for addressing the
7 needs of each jurisdiction identified in the report.

8 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated such sums as necessary
10 to carry out this section.

11 **“CHAPTER 2—NATIONAL HEALTH SAFETY**
12 **NET INFRASTRUCTURE**

13 **“Subchapter A—General Provisions**

14 **“SEC. 2952. PAYMENTS TO HEALTHCARE FACILITIES.**

15 “(a) IN GENERAL.—The Secretary, with the approval
16 of the Health Safety Net Infrastructure Trust Fund
17 Board of Trustees described in section 2972C(d) (here-
18 after in this subtitle referred to as the ‘Trust Fund
19 Board’), shall make payments, from amounts in the
20 Health Safety Net Infrastructure Trust Fund established
21 under section 2972C(a) (hereafter in this subtitle referred
22 to as the ‘Trust Fund’), for capital financing assistance
23 to eligible healthcare facilities whose applications for as-
24 sistance have been approved under this subtitle.



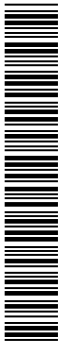
1 “(b) GENERAL ELIGIBILITY REQUIREMENTS FOR AS-
2 SISTANCE.—

3 “(1) ELIGIBLE HEALTHCARE FACILITIES DE-
4 SCRIBED.—

5 “(A) IN GENERAL.—A healthcare facility
6 shall be generally eligible for capital financing
7 assistance under this subtitle if the healthcare
8 facility—

9 “(i) receives an additional payment
10 under section 1886(d)(5)(F) of the Social
11 Security Act and is described in clause
12 (i)(II) or clause (vii)(I) of such section, or
13 is deemed a disproportionate share hospital
14 under a State plan for medical assistance
15 under title XIX of the Social Security Act
16 on the basis described in section
17 1923(b)(1) of such Act;

18 “(ii) is a hospital which meets the cri-
19 teria for designation by the Secretary as
20 an essential access community hospital
21 under section 1820(i)(1) of such Act or a
22 rural primary care hospital under section
23 1820(i)(2) of such Act (whether or not
24 such hospital is actually designated under
25 such section);



1 “(iii) is a Federally qualified health
2 center (as defined in section 1905(l)(2)(B)
3 of such Act);

4 “(iv) is a hospital which—

5 “(I) is a sole community pro-
6 vider; or

7 “(II) has closed within the pre-
8 ceding 12 months;

9 “(v) is a facility which—

10 “(I) provides service to ill or in-
11 jured individuals prior to the trans-
12 portation of such individuals to a hos-
13 pital or provides inpatient care to in-
14 dividuals needing such care for a pe-
15 riod not longer than 96 hours;

16 “(II) is located in a county (or
17 equivalent unit of local government)
18 with fewer than 6 residents per
19 square mile or is located more than
20 35 road miles from the nearest hos-
21 pital;

22 “(III) permits a physician assist-
23 ant or nurse practitioner to admit and
24 treat patients under the supervision of



1 a physician not present in such facil-
2 ity; and

3 “(IV) has obtained a waiver from
4 the Secretary permitting the facility
5 to participate in the medicare pro-
6 gram under title XVIII of the Social
7 Security Act; or

8 “(vi) is a hospital that the Secretary
9 otherwise determines to be an appropriate
10 recipient of assistance under this subtitle
11 on the basis of the existence of a patient
12 care operating deficit, a demonstrated in-
13 ability to secure or repay financing for a
14 qualifying project on reasonable terms, or
15 such other criteria as the Secretary con-
16 siders appropriate.

17 “(B) DEVELOPMENT OF CRITERIA.—For
18 purposes of subparagraph (A)(vi), with respect
19 to rural hospitals which are at risk or critical
20 to healthcare access, the Prospective Payment
21 Review Commission, not later than January 1,
22 2006, shall develop criteria to assist the Sec-
23 retary in deciding if such hospitals deserve as-
24 sistance, after considering, at a minimum, the
25 following factors:



1 “(i) AT-RISK RURAL HOSPITALS.—In
2 the case of rural hospitals the closure of
3 which within the next year is imminent or
4 the continued operation of which over a 2-
5 to 5-year period is questionable, such fac-
6 tors as the level of health resources avail-
7 able in a community as measured by physi-
8 cian supply, the population base of the
9 area served by the hospital and utilization
10 of services by such population as measured
11 by service area population, and financial
12 indicators predictive of closure.

13 “(ii) RURAL HOSPITALS CRITICAL TO
14 HEALTHCARE ACCESS.—In the case of
15 rural hospitals which provide access to es-
16 sential health services within a service area
17 where no other provider of such essential
18 services exists, such factors as the market
19 share of the hospital for an area or popu-
20 lation, the number of outpatient visits, the
21 proximity of the next closest provider of
22 such services, and the degree to which the
23 area population is medically underserved.

24 “(2) OWNERSHIP REQUIREMENTS.—In order to
25 be eligible for assistance under this subtitle, a



1 healthcare facility (other than a healthcare facility
2 described in clauses (ii) and (v) of paragraph (1))
3 must—

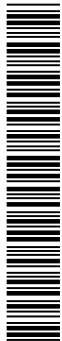
4 “(A) be owned or operated by a unit of
5 State or local government;

6 “(B) be a quasi-public corporation, defined
7 as a private, nonprofit corporation or public
8 benefit corporation which is formally granted
9 one or more governmental powers by legislative
10 action through (or is otherwise partially funded
11 by) the State legislature, city or county council;

12 “(C) be a private nonprofit healthcare fa-
13 cility which has contracted with, or is otherwise
14 funded by, a governmental agency to provide
15 healthcare services to low income individuals
16 not eligible for assistance under title XVIII or
17 title XIX of the Social Security Act, where rev-
18 enue from such contracts constitute at least 10
19 percent of the facility’s operating revenues over
20 the prior 3 fiscal years; or

21 “(D) be a nonprofit small rural healthcare
22 facility (as determined by the Secretary).

23 “(3) PRIORITY.—In making payments under
24 this section, the Secretary shall give priority to eligi-
25 ble healthcare entities that are federally qualified



1 health centers (as defined in section 1905(l)(2)(B)
2 of the Social Security Act), or other similar entities
3 at least 50 percent of the patients of which are mi-
4 nority or low-income individuals.

5 “(c) MEETING ADDITIONAL SPECIFIC CRITERIA.—
6 Healthcare facilities that are generally eligible for assist-
7 ance under this subtitle under subsection (b) may apply
8 for the specific programs described in this subtitle and
9 must meet any additional criteria for participation in such
10 programs.

11 “(d) ASSISTANCE AVAILABLE.—Capital financing as-
12 sistance available under this subtitle shall include loan
13 guarantees, interest rate subsidies, matching loans and di-
14 rect grants. Healthcare facilities determined to be gen-
15 erally eligible for assistance under this subtitle may apply
16 for and receive more than one type of assistance under
17 this subtitle.

18 **“SEC. 2952A. APPLICATION FOR ASSISTANCE.**

19 “(a) IN GENERAL.—No healthcare facilities may re-
20 ceive assistance for a qualifying project under this subtitle
21 unless the healthcare facility—

22 “(1) has filed with the Secretary, in a form and
23 manner specified by the Secretary, with the advice
24 and approval of the Trust Fund Board (as described



1 in section 2972C(d)), an application for assistance
2 under this subtitle;

3 “(2) establishes in its application (for its most
4 recent cost reporting period) that it meets the cri-
5 teria for general eligibility under this subtitle;

6 “(3) includes a description of the project, in-
7 cluding the community in which it is located, and
8 describes utilization and services characteristics of
9 the project and the healthcare facility, and the pa-
10 tient population that is to be served;

11 “(4) describes the extent to which the project
12 will include the financial participation of State and
13 local governments if assistance is granted under this
14 subtitle, and all other sources of financing sought
15 for the project; and

16 “(5) establishes, to the satisfaction of the Sec-
17 retary and the Trust Fund Board, that the project
18 meets the additional criteria for each type of capital
19 financing assistance for which it is applying.

20 “(b) CRITERIA FOR APPROVAL.—The Secretary, with
21 the approval of the Trust Fund Board, shall determine
22 for each application for assistance under this subtitle—

23 “(1) whether the healthcare facility meets the
24 general eligibility criteria under section 2972(b);



1 “(2) whether the healthcare facility meets the
2 specific eligibility criteria of each type of assistance
3 for which it has applied, including whether the
4 healthcare facility meets any criteria for priority
5 consideration for the type of assistance for which it
6 has applied;

7 “(3) whether the capital project for which as-
8 sistance is being requested is a qualifying project
9 under this subtitle; and

10 “(4) whether funds are available, pursuant to
11 the limitations of each program, to fully fund the re-
12 quest for assistance.

13 “(c) PRIORITY OF APPLICATIONS.—In addition to
14 meeting the criteria otherwise described in this subtitle,
15 at the discretion of the Trust Fund Board, the Secretary
16 shall give preference to those applications for qualifying
17 projects that—

18 “(1)(A) are necessary to bring existing safety
19 net healthcare facilities into compliance with accredi-
20 tation standards of fire and life safety, seismic, or
21 other related Federal, State or local regulatory
22 standards;

23 “(B) improve the provision of essential services
24 such as emergency medical and trauma services,
25 AIDS and infectious disease, perinatal, burn, pri-



1 mary care, and other services which the Trust Fund
2 Board may designate; or

3 “(C) provide access to otherwise unavailable es-
4 sential health services to the indigent and other
5 needy persons within the healthcare facility’s terri-
6 torial area;

7 “(2) include specific State or local governmental
8 or other non-Federal assurances of financial support
9 if assistance for a qualifying project is granted
10 under this subtitle; and

11 “(3) are unlikely to be financed without assist-
12 ance granted under this subtitle.

13 “(d) SUBMISSION OF APPLICATIONS.—Applications
14 under this subtitle shall be submitted to the Secretary
15 through the Trust Fund Board. If two or more healthcare
16 facilities join in the project, the application shall be sub-
17 mitted by all participating healthcare facilities jointly.
18 Such applications shall set forth all of the descriptions,
19 plans, specifications, and assurances as required by this
20 subtitle and contain other such information as the Trust
21 Fund Board shall require.

22 “(e) OPPORTUNITY FOR APPEAL.—The Trust Fund
23 Board shall afford a healthcare facility applying for a loan
24 guarantee under this section an opportunity for a hearing
25 if the guarantee is denied.



1 “(f) APPLICATIONS FOR AMENDMENTS.—Amend-
2 ment of an approved application shall be subject to ap-
3 proval in the same manner as an original application.

4 **“SEC. 2952B. PUBLIC SERVICE RESPONSIBILITIES.**

5 “(a) IN GENERAL.—Any healthcare facility accepting
6 capital financing assistance under this subtitle shall
7 agree—

8 “(1) to make the services of the facility or por-
9 tion thereof to be constructed, acquired, or modern-
10 ized available to all persons; and

11 “(2) to provide a significant volume of services
12 to persons unable to pay therefore, consistent with
13 other provisions of this Act and the amount of as-
14 sistance received under this subtitle.

15 “(b) ENFORCEMENT.—The Director of the Office for
16 Civil Rights of the Department of Health and Human
17 Services shall be given the power to enforce the public
18 service responsibilities described in this section.

19 **“SEC. 2952C. HEALTH SAFETY NET INFRASTRUCTURE**
20 **TRUST FUND.**

21 “(a) CREATION OF TRUST FUND.—There is estab-
22 lished in the Treasury of the United States a trust fund
23 to be known as the Health Safety Net Infrastructure
24 Trust Fund, consisting of such amounts as may be trans-



1 ferred, appropriated, or credited to such Trust Fund as
2 provided in this subtitle.

3 “(b) AUTHORIZATION OF APPROPRIATIONS TO
4 TRUST FUND.—There are authorized to be appropriated
5 to the Trust Fund such sums as may be necessary to carry
6 out the purposes of this subtitle.

7 “(c) EXPENDITURES FROM TRUST FUND.—Amounts
8 in the Trust Fund shall be available, pursuant to appro-
9 priations Acts, only for making expenditures to carry out
10 the purposes of this subtitle.

11 “(d) BOARD OF TRUSTEES; COMPOSITION; MEET-
12 INGS; DUTIES.—

13 “(1) IN GENERAL.—There shall be created a
14 Health Safety Net Infrastructure Trust Fund Board
15 of Trustees composed of the Secretary of Health and
16 Human Services, the Secretary of the Treasury, the
17 Assistant Secretary for Health, the Director of the
18 Office of Minority Health, and the Administrator of
19 the Centers for Medicare and Medicaid Services (all
20 serving in their ex officio capacities), and 5 public
21 members who shall be appointed for 4 year terms by
22 the President, from the following categories—

23 “(A) one chief health officer from a State;



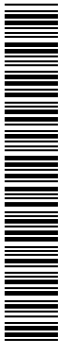
1 “(B) one chief executive officer of a
2 healthcare facility that meets the general eligi-
3 bility criteria of this subtitle;

4 “(C) one representative of the financial
5 community; and

6 “(D) two additional public or consumer
7 representatives.

8 “(2) DUTIES.—The Board of Trustees shall
9 meet no less than quarterly and shall have the re-
10 sponsibility to approve implementing regulations, to
11 establish criteria, and to recommend and approve ex-
12 penditures by the Secretary under the programs set
13 forth in this subtitle.

14 “(3) MANAGING TRUSTEE.—The Secretary of
15 the Treasury shall serve as the Managing Trustee of
16 the Trust Fund, and shall be responsible for the in-
17 vestment of funds. The provisions of subsections (b)
18 through (e) of section 1817 of the Social Security
19 Act shall apply to the Trust Fund and the Managing
20 Trustee of the Trust Fund in the same manner as
21 they apply to the Federal Hospital Insurance Trust
22 Fund and the Managing Trustee of that Trust
23 Fund.



1 **“SEC. 2952D. ADMINISTRATION.**

2 “(a) IN GENERAL.—The Administrator of the Cen-
3 ters for Medicare and Medicaid Services shall serve as Sec-
4 retary of the Board of Trustees and shall administer the
5 programs under this subtitle.

6 “(b) LIMITATION ON ADMINISTRATIVE EXPENSES.—
7 Not more than 5 percent of the funds annually appro-
8 priated to the Trust Fund may be available for adminis-
9 tration of the Trust Fund or programs under this subtitle.

10 **“Subchapter B—Loan Guarantees**

11 **“SEC. 2953. PROVISION OF LOAN GUARANTEES TO SAFETY**
12 **NET HEALTHCARE FACILITIES.**

13 “(a) IN GENERAL.—The Safety Net Infrastructure
14 Trust Fund will provide a Federal guarantee of loan re-
15 payment, including guarantees of repayment of refi-
16 nancing loans, to non-Federal lenders making loans to eli-
17 gible healthcare facilities for healthcare facility replace-
18 ment (either by construction or acquisition), moderniza-
19 tion and renovation projects, and capital equipment acqui-
20 sition.

21 “(b) PURPOSES.—The loan guarantee program shall
22 be designed by the Trust Fund Board with the goal of
23 rebuilding and maintaining the essential health services of
24 healthcare facilities eligible for assistance under this sub-
25 title.



1 **“SEC. 2953A. ELIGIBLE LOANS.**

2 “(a) IN GENERAL.—Loan guarantees under this
3 chapter are available for loans made to eligible healthcare
4 facilities for replacement facilities (either newly con-
5 structed or acquired), modernization and renovation of ex-
6 isting facilities, and for capital equipment acquisition.

7 “(b) LOAN GUARANTEE MUST BE ESSENTIAL TO
8 BOND FINANCING.—Eligible healthcare facilities must
9 demonstrate that a Federal loan guarantee is essential to
10 obtaining bond financing from non-Federal lenders at a
11 reasonably affordable rate of interest.

12 “(c) ADDITIONAL ELIGIBILITY CRITERIA FOR LOAN
13 GUARANTEES.—In order to be eligible for assistance
14 under this chapter, a healthcare facility must demonstrate
15 that the following criteria are met:

16 “(1) The healthcare facility has evidence of an
17 ability to meet debt service.

18 “(2) The assistance, when considered with other
19 resources available to the project, is necessary and
20 will restore, improve, or maintain the financial or
21 physical soundness of the healthcare facility.

22 “(3) The applicant agrees to assume the public
23 service responsibilities described in section 2952B.

24 “(4) The project is being, or will be, operated
25 and managed in accordance with a management-im-
26 provement-and-operating plan which is designed to



1 reduce the operating costs of the project, which has
2 been approved by the Trust Fund Board, and which
3 includes—

4 “(A) a detailed maintenance schedule;

5 “(B) a schedule for correcting past defi-
6 ciencies in maintenance, repairs, and replace-
7 ments;

8 “(C) a plan to upgrade the project to meet
9 cost-effective energy efficiency standards pre-
10 scribed by the Trust Fund Board;

11 “(D) a plan to improve financial and man-
12 agement control systems;

13 “(E) a detailed annual operating budget
14 taking into account such standards for oper-
15 ating costs in the area as may be determined by
16 the Trust Fund Board; and

17 “(F) such other requirements as the Trust
18 Fund Board may determine.

19 “(5) The application includes stringent provi-
20 sions for continued State or local support of the pro-
21 gram, both with respect to operating and financial
22 capital.

23 “(6) The terms, conditions, maturity, security
24 (if any), and schedule and amount of repayments
25 with respect to the loan are sufficient to protect the



1 financial interests of the United States and are oth-
2 erwise reasonable and in accord with regulation, in-
3 cluding a determination that the rate of interest
4 does not exceed such annual percentage on the prin-
5 cipal obligation outstanding as the Trust Fund
6 Board determines to be reasonable, taking into ac-
7 count the range of interest rates prevailing in the
8 private market for similar loans and the risks as-
9 sumed by the United States.

10 “(7) The healthcare facility must meet such
11 other additional criteria as the Secretary may im-
12 pose.

13 “(e) STATE OR LOCAL PARTICIPATION.—Projects in
14 which State or local governmental entities participate in
15 the form of first guarantees of part or all of the total loan
16 value shall be given a preference for loan guarantees under
17 this chapter.

18 **“SEC. 2953B. GUARANTEE ALLOTMENTS.**

19 “(a) IN GENERAL.—\$150,000,000 shall be annually
20 allocated within the Trust Fund to the loan guarantee pro-
21 gram established by this chapter in order to create a cu-
22 mulative reserve in support of loan guarantees.

23 “(b) LOAN GUARANTEES FOR RURAL HEALTHCARE
24 FACILITIES.—At least 20 percent of the dollar value of
25 loan guarantees made under this program during any



1 given year shall be allocated for eligible rural healthcare
2 facilities, to the extent a sufficient number of applications
3 are made by such healthcare facilities.

4 “(c) GUARANTEES FOR SMALL LOANS.—At least
5 \$200,000,000 of the annual dollar value of loan guaran-
6 tees made under the program shall be reserved for loans
7 of under \$50,000,000, if there are a sufficient number of
8 applicants for loans of that size.

9 “(d) SPECIAL RULE FOR REFINANCING LOANS.—
10 Not more than 20 percent of the amount allocated each
11 year to the loan guarantee program established by this
12 chapter may be allocated to guarantee refinancing loans
13 during the year.

14 **“SEC. 2953C. TERMS AND CONDITIONS OF LOAN GUARAN-**
15 **TEES.**

16 “(a) IN GENERAL.—The principal amount of the
17 guaranteed loan, when added to any Federal grant assist-
18 ance made under this subtitle, may not exceed 95 percent
19 of the total value of the project, including land.

20 “(b) GUARANTEES PROVIDED MAY NOT SUPPLANT
21 OTHER FUNDS.—Guarantees provided under this chapter
22 may not be used to supplant other forms of State or local
23 support.

24 “(c) RIGHT TO RECOVER FUNDS.—The United
25 States shall be entitled to recover from any applicant



1 healthcare facility the amount of payments made pursuant
2 to any loan guarantee under this chapter, unless the Trust
3 Fund Board for good cause waives its right of recovery,
4 and the United States shall, upon making any such pay-
5 ment pursuant to any such loan guarantee be subrogated
6 to all of the rights of the recipients of the payments.

7 “(d) MODIFICATION OF TERMS.—Loan guarantees
8 made under this chapter shall be subject to further terms
9 and conditions as the Trust Fund Board determines to
10 be necessary to assure that the purposes of this Act will
11 be achieved, and any such terms and conditions may be
12 modified by the Trust Fund Board to the extent that it
13 determines such modifications to be consistent with the
14 financial interest of the United States.

15 “(e) TERMS ARE INCONTESTABLE ABSENT FRAUD
16 OR MISREPRESENTATION.—Any loan guarantee made by
17 the Trust Fund Board pursuant to this chapter shall be
18 incontestable in the hands of an applicant on whose behalf
19 such guarantee is made, and as to any person who makes
20 or contracts to make a loan to such applicant in reliance
21 thereon, except for fraud or misrepresentation on the part
22 of such applicant or other person.

23 **“SEC. 2953D. PREMIUMS FOR LOAN GUARANTEES.**

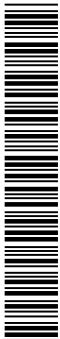
24 “(a) IN GENERAL.—The Trust Fund Board shall de-
25 termine a reasonable loan insurance premium which shall



1 be charged for loan guarantees under this chapter, taking
2 into account the availability of the reserves created under
3 section 2953B. Premium charges shall be payable in cash
4 to the Trust Fund Board, either in full upon issuance,
5 or annually in advance. In addition to the premium charge
6 herein provided for, the Trust Fund Board is authorized
7 to charge and collect such amount as it may deem reason-
8 able for the appraisal of a property or project offered for
9 insurance and for the inspection of such property or
10 project.

11 “(b) PAYMENT IN ADVANCE.—In the event that the
12 principal obligation of any loan accepted for insurance
13 under this chapter is paid in full prior to the maturity
14 date, the Trust Fund Board is authorized in its discretion
15 to require the payment by the borrower of an adjusted
16 premium charge in such amount as the Board determines
17 to be equitable, but not in excess of the aggregate amount
18 of the premium charges that the healthcare facility would
19 otherwise have been required to pay if the loan had contin-
20 ued to be insured until maturity date.

21 “(c) TRUST FUND BOARD MAY WAIVE PREMIUMS.—
22 The Trust Fund Board may in its discretion partially or
23 totally waive premiums charged for loan insurance under
24 this section for financially distressed healthcare facilities
25 (as described by the Secretary).



1 **“SEC. 2953E. PROCEDURES IN THE EVENT OF LOAN DE-**
2 **FAULT.**

3 “(a) IN GENERAL.—Failure of the borrower to make
4 payments due under or provided by the terms of a loan
5 accepted for insurance under this chapter shall constitute
6 a default.

7 “(b) ASSIGNMENT OF DEFAULTED LOANS.—If a de-
8 fault continues for 30 days, then, upon the lender’s trans-
9 fer to the Trust Fund Board of all its rights and interests
10 arising under the defaulted loan or in connection with the
11 loan transaction, the lender shall be entitled to debentures
12 which, together with a certificate of claim, are equal in
13 value to the amount the lender would have received if, on
14 the date of transfer, the borrower had repaid the loan in
15 full, together with the amount of necessary expenses in-
16 curred by the lender in connection with the default.

17 “(c) FORECLOSURE BY LENDER.—Subject to the ap-
18 proval of the Trust Fund Board, or as provided in regula-
19 tions, the lender may foreclose on the property securing
20 the defaulted loan.

21 “(d) FORECLOSURE BY TRUST FUND BOARD.—The
22 Trust Fund Board is authorized to—

23 “(1) acquire possession of and title to any prop-
24 erty securing a defaulted loan by voluntary convey-
25 ance in extinguishment of the indebtedness, or



1 “(2) institute proceedings for foreclosure on the
2 property securing any such defaulted loan and pros-
3 ecute such proceedings to conclusion.

4 “(e) HANDLING AND DISPOSAL OF PROPERTY; SET-
5 TLEMENT OF CLAIMS.—

6 “(1) PAYMENT FOR CERTAIN EXPENSES.—Not-
7 withstanding any other provision of law relating to
8 the acquisition, handling, or disposal of real and
9 other property by the United States, the Trust Fund
10 Board shall also have power, for the protection of
11 the interests of the Trust Fund, to pay out of the
12 Trust Fund all expenses or charges in connection
13 with, and to deal with, complete, reconstruct, rent,
14 renovate, modernize, insure, make contracts for the
15 management of, or establish suitable agencies for
16 the management of, or sell for cash or credit or lease
17 in its discretion, any property acquired by the Trust
18 Fund under this section.

19 “(2) SETTLEMENT OF CLAIMS.—Notwith-
20 standing any other provision of law, the Trust Fund
21 Board shall also have the power to pursue to final
22 collection by way of compromise or otherwise all
23 claims assigned and transferred to the Trust Fund
24 in connection with the assignment, transfer, and de-
25 livery provided for in this section, and at any time,



1 upon default, to foreclose or refrain from foreclosing
2 on any property secured by any defaulted loan as-
3 signed and transferred to or held by the Trust
4 Fund.

5 “(3) LIMITATIONS ON AUTHORITY.—Sub-
6 sections (a) and (b) shall not be construed to apply
7 to any contract for hazard insurance, or to any pur-
8 chase or contract for services or supplies on account
9 of such property if the amount thereof does not ex-
10 ceed \$1,000.

11 “(f) REGULATIONS.—The Trust Fund Board shall
12 propose and the Secretary shall promulgate regulations
13 governing procedures in the event of a default on a loan
14 accepted for insurance under this chapter.

15 **“Subchapter C—Grants for Urgent Capital**
16 **Needs**

17 **“SEC. 2956. PROVISION OF GRANTS.**

18 “(a) IN GENERAL.—The Trust Fund Board shall
19 make available \$400,000,000 in direct grants annually.
20 The Secretary, with the approval of the Trust Fund
21 Board, shall make direct grants to eligible healthcare fa-
22 cilities with urgent capital needs.

23 “(b) PURPOSES.—Direct grants shall be available to
24 eligible healthcare facilities for 3 types of projects:



1 “(1) Emergency certification and licensure
2 grants would be available to eligible healthcare facili-
3 ties that are threatened with closure or loss of ac-
4 creditation or certification of a facility or of essential
5 services as a result of life or safety code violations
6 or similar facility or equipment failures. Such grants
7 would provide limited funding for repair and renova-
8 tion where failure to fund would disrupt the provi-
9 sion of essential public health services such as emer-
10 gency care.

11 “(2) Emergency grants would be available for
12 capital renovation, expansion, or replacement nec-
13 essary to the maintenance or expansion of essential
14 safety and health services such as obstetrics,
15 perinatal, emergency and trauma, primary care and
16 preventive health services.

17 “(3) Planning grants would be available to eli-
18 gible healthcare facilities who require pre-approval
19 assistance to meet regulatory requirements related
20 to management and finance in order to apply for
21 loans, loan guarantees, and interest subsidies under
22 this subtitle.

23 “(c) PRIORITY TO FINANCIALLY DISTRESSED
24 HEALTHCARE FACILITIES.—Priority for direct grants



1 under this section would be given to financially distressed
2 healthcare facilities (as described by the Secretary).

3 “(d) APPLICATION PROCESS.—The Secretary, with
4 the approval of the Trust Fund Board, shall create an
5 expedited application process for direct grants.

6 **“SEC. 2956B. ELIGIBLE PROJECTS.**

7 “(a) MATCHING GRANTS.—

8 “(1) LIMITATION ON AMOUNT.—Grants for cap-
9 ital expenditures by eligible healthcare facilities will
10 be limited to \$25,000,000.

11 “(2) MATCHING REQUIREMENT.—At least half
12 of the projects funded in a year must receive at least
13 50 percent of their funding from State or local
14 sources. The remaining projects funded during the
15 year could be financed up to 90 percent with a com-
16 bination of Federal grants and loans.

17 “(3) RESERVATION FOR RURAL HEALTHCARE
18 FACILITIES.—No less than 20 percent of the grant
19 funds in any given year would be reserved for rural
20 healthcare facilities, provided that a sufficient num-
21 ber of applications are approved.

22 “(b) PLANNING GRANTS.—Applicants who can dem-
23 onstrate general qualification for the direct matching loan,
24 loan guarantee, or interest subsidy programs under this
25 subtitle or eligibility for mortgage insurance under section



1 242 of the National Housing Act will be eligible for a
2 grant of up to \$500,000 to assist in implementation of
3 key budgetary and financial systems as well as manage-
4 ment and governance restructuring.”.

5 **SEC. 702. ESTABLISHMENT OF ALEJANDRO GARCIA NA-**
6 **TIONAL CENTER FOR SOCIAL WORK RE-**
7 **SEARCH.**

8 Title V of the Public Health Service Act (42 U.S.C.
9 290aa et seq.) is amended by adding at the end the fol-
10 lowing:

11 **“PART J—ALEJANDRO GARCIA NATIONAL**
12 **CENTER FOR SOCIAL WORK RESEARCH**

13 **“SEC. 597. PURPOSE OF CENTER.**

14 “The general purpose of the Alejandro Garcia Na-
15 tional Center for Social Work Research (referred to in this
16 part as the ‘Center’) is the conduct and support of, and
17 dissemination of targeted research on social work methods
18 and outcomes related to problems of significant social con-
19 cern. The Center shall promote research and training de-
20 signed to inform social work practice, thus increasing the
21 knowledge base which promotes a healthier America. In
22 addition, the Center shall provide policymakers with em-
23 pirically-based research information to better understand
24 complex social issues and make informed funding decisions
25 about service effectiveness and cost efficiency.



1 **“SEC. 597A. SPECIFIC AUTHORITIES.**

2 “(a) IN GENERAL.—To carry out the purpose de-
3 scribed in section 597, the Director of the Center may pro-
4 vide research training and instruction and establish, in the
5 Center and in other nonprofit institutions, research
6 traineeships and fellowships in the study and investigation
7 of the prevention of disease, health promotion, the associa-
8 tion of socioeconomic status, gender, ethnicity, age, and
9 geographical location and health, the social work care of
10 persons with and families of individuals with acute and
11 chronic illnesses, child abuse, neglect, and youth violence,
12 and child and family care to address problems of signifi-
13 cant social concern especially in underserved populations
14 and underserved geographical areas.

15 “(b) STIPENDS AND ALLOWANCES.—The Director of
16 the Center may provide individuals receiving training and
17 instruction or traineeships or fellowships under subsection
18 (a) with such stipends and allowances (including amounts
19 for travel and subsistence and dependency allowances) as
20 the Director determines necessary.

21 “(c) GRANTS.—The Director of the Center may make
22 grants to nonprofit institutions to provide training and in-
23 struction and traineeships and fellowships under sub-
24 section (a).

25 **“SEC. 597B. ADVISORY COUNCIL.**

26 “(a) DUTIES.—



1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish an advisory council for the Center that shall ad-
3 vise, assist, consult with, and make recommenda-
4 tions to the Secretary and the Director of the Center
5 on matters related to the activities carried out by
6 and through the Center and the policies with respect
7 to such activities.

8 “(2) GIFTS.—The advisory council for the Cen-
9 ter may recommend to the Secretary the acceptance,
10 in accordance with section 231, of conditional gifts
11 for study, investigations, and research and for the
12 acquisition of grounds or construction, equipment, or
13 maintenance of facilities for the Center.

14 “(3) OTHER DUTIES AND FUNCTIONS.—The
15 advisory council for the Center—

16 “(A)(i) may make recommendations to the
17 Director of the Center with respect to research
18 to be conducted by the Center;

19 “(ii) may review applications for grants
20 and cooperative agreements for research or
21 training and recommend for approval applica-
22 tions for projects that demonstrate the prob-
23 ability of making valuable contributions to
24 human knowledge; and



1 “(iii) may review any grant, contract, or
2 cooperative agreement proposed to be made or
3 entered into by the Center;

4 “(B) may collect, by correspondence or by
5 personal investigation, information relating to
6 studies that are being carried out in the United
7 States or any other country and, with the ap-
8 proval of the Director of the Center, make such
9 information available through appropriate publi-
10 cations; and

11 “(C) may appoint subcommittees and con-
12 vene workshops and conferences.

13 “(b) MEMBERSHIP.—

14 “(1) IN GENERAL.—The advisory council shall
15 be composed of the ex officio members described in
16 paragraph (2) and not more than 18 individuals to
17 be appointed by the Secretary under paragraph (3).

18 “(2) EX OFFICIO MEMBERS.—The ex officio
19 members of the advisory council shall include—

20 “(A) the Secretary of Health and Human
21 Services, the Director of NIH, the Director of
22 the Center, the Director of the Office of Behav-
23 ioral and Social Sciences Research, the Chief
24 Social Work Officer of the Veterans’ Adminis-
25 tration, the Assistant Secretary of Defense for

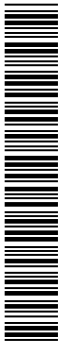


1 Health Affairs, the Associate Director of Pre-
2 vention Research at the National Institute of
3 Mental Health, the Director of the Centers for
4 Disease Control and Prevention, the Director of
5 the Division of Epidemiology and Services Re-
6 search, the Assistant Secretary of Health and
7 Human Services for the Administration for
8 Children and Families, the Assistant Secretary
9 of Education for the Office of Educational Re-
10 search and Improvement, the Assistant Sec-
11 retary of Housing and Urban Development for
12 Community Planning and Development, and the
13 Assistant Attorney General for Office of Justice
14 Programs (or the designees of such officers);
15 and

16 “(B) such additional officers or employees
17 of the United States as the Secretary deter-
18 mines necessary for the advisory council to ef-
19 fectively carry out its functions.

20 “(3) APPOINTED MEMBERS.—The Secretary
21 shall appoint not to exceed 18 individuals to the ad-
22 visory council, of which—

23 “(A) not more than two-thirds of such in-
24 dividual shall be appointed from among the
25 leading representatives of the health and sci-



1 entific disciplines (including public health and
2 the behavioral or social sciences) relevant to the
3 activities of the Center, and at least 7 such in-
4 dividuals shall be professional social workers
5 who are recognized experts in the area of clin-
6 ical practice, education, policy, or research; and
7 “(B) not more than one-third of such indi-
8 viduals shall be appointed from the general
9 public and shall include leaders in fields of pub-
10 lic policy, law, health policy, economics, and
11 management.

12 The Secretary shall make appointments to the advi-
13 sory council in such a manner as to ensure that the
14 terms of the members do not all expire in the same
15 year.

16 “(4) COMPENSATION.—Members of the advi-
17 sory council who are officers or employees of the
18 United States shall not receive any compensation for
19 service on the advisory council. The remaining mem-
20 bers shall receive, for each day (including travel
21 time) they are engaged in the performance of the
22 functions of the advisory council, compensation at
23 rates not to exceed the daily equivalent of the annual
24 rate in effect for an individual at grade GS-18 of
25 the General Schedule.



1 “(c) TERMS.—

2 “(1) IN GENERAL.—The term of office of an in-
3 dividual appointed to the advisory council under sub-
4 section (b)(3) shall be 4 years, except that any indi-
5 vidual appointed to fill a vacancy on the advisory
6 council shall serve for the remainder of the unex-
7 pired term. A member may serve after the expiration
8 of the member’s term until a successor has been ap-
9 pointed.

10 “(2) REAPPOINTMENTS.—A member of the ad-
11 visory council who has been appointed under sub-
12 section (b)(3) for a term of 4 years may not be re-
13 appointed to the advisory council prior to the expira-
14 tion of the 2-year period beginning on the date on
15 which the prior term expired.

16 “(3) VACANCY.—If a vacancy occurs on the ad-
17 visory council among the members under subsection
18 (b)(3), the Secretary shall make an appointment to
19 fill that vacancy not later than 90 days after the
20 date on which the vacancy occurs.

21 “(d) CHAIRPERSON.—The chairperson of the advi-
22 sory council shall be selected by the Secretary from among
23 the members appointed under subsection (b)(3), except
24 that the Secretary may select the Director of the Center



1 to be the chairperson of the advisory council. The term
2 of office of the chairperson shall be 2 years.

3 “(e) MEETINGS.—The advisory council shall meet at
4 the call of the chairperson or upon the request of the Di-
5 rector of the Center, but not less than 3 times each fiscal
6 year. The location of the meetings of the advisory council
7 shall be subject to the approval of the Director of the Cen-
8 ter.

9 “(f) ADMINISTRATIVE PROVISIONS.—The Director of
10 the Center shall designate a member of the staff of the
11 Center to serve as the executive secretary of the advisory
12 council. The Director of the Center shall make available
13 to the advisory council such staff, information, and other
14 assistance as the council may require to carry out its func-
15 tions. The Director of the Center shall provide orientation
16 and training for new members of the advisory council to
17 provide such members with such information and training
18 as may be appropriate for their effective participation in
19 the functions of the advisory council.

20 “(g) COMMENTS AND RECOMMENDATIONS.—The ad-
21 visory council may prepare, for inclusion in the biennial
22 report under section 597C—

23 “(1) comments with respect to the activities of
24 the advisory council in the fiscal years for which the
25 report is prepared;



1 “(2) comments on the progress of the Center in
2 meeting its objectives; and

3 “(3) recommendations with respect to the fu-
4 ture direction and program and policy emphasis of
5 the center.

6 The advisory council may prepare such additional reports
7 as it may determine appropriate.

8 **“SEC. 597C. BIENNIAL REPORT.**

9 “The Director of the Center, after consultation with
10 the advisory council for the Center, shall prepare for inclu-
11 sion in the biennial report under section 403, a biennial
12 report that shall consist of a description of the activities
13 of the Center and program policies of the Director of the
14 Center in the fiscal years for which the report is prepared.
15 The Director of the Center may prepare such additional
16 reports as the Director determines appropriate. The Di-
17 rector of the Center shall provide the advisory council of
18 the Center an opportunity for the submission of the writ-
19 ten comments described in section 597B(g).

20 **“SEC. 597D. QUARTERLY REPORT.**

21 “The Director of the Center shall prepare a quarterly
22 report to Congress with a summary of findings and policy
23 implications from research conducted or supported
24 through the Center.



1 **“SEC. 597E. AUTHORIZATION OF APPROPRIATIONS.**

2 “For the purpose of carrying out this part, there is
3 authorized to be appropriated \$30,000,000 for each of the
4 fiscal years 2006 through 2010.”.

5 **SEC. 703. ANNIE DODGE WAUNKA AND SUSAN LAFLESCHE-**

6 **PICOTTE NATIVE AMERICAN HEALTH AND**

7 **WELLNESS FOUNDATION.**

8 (a) IN GENERAL.—The Indian Self-Determination
9 and Education Assistance Act (25 U.S.C. 450 et seq.) is
10 amended by adding at the end the following:

11 **“TITLE VIII—ANNIE DODGE**
12 **WAUNKA AND SUSAN**
13 **LAFLESCHE-PICOTTE NATIVE**
14 **AMERICAN HEALTH AND**
15 **WELLNESS FOUNDATION**

16 **“SEC. 801. DEFINITIONS.**

17 “In this title:

18 “(1) BOARD.—The term ‘Board’ means the
19 Board of Directors of the Foundation.

20 “(2) COMMITTEE.—The term ‘Committee’
21 means the Committee for the Establishment of the
22 Annie Dodge Wauneka and Susan Laflesche-Picotte
23 Native American Health and Wellness Foundation
24 established under section 802(f).

25 “(3) FOUNDATION.—The term ‘Foundation’
26 means the Annie Dodge Wauneka and Susan



1 Laflesche-Picotte Native American Health and
2 Wellness Foundation established under section 802.

3 “(4) SECRETARY.—The term ‘Secretary’ means
4 the Secretary of Health and Human Services.

5 “(5) SERVICE.—The term ‘Service’ means the
6 Indian Health Service of the Department of Health
7 and Human Services.

8 **“SEC. 802. ANNIE DODGE WAUNEKA AND SUSAN**
9 **LAFLESCHE-PICOTTE NATIVE AMERICAN**
10 **HEALTH AND WELLNESS FOUNDATION.**

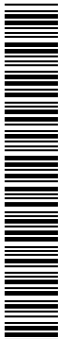
11 “(a) IN GENERAL.—As soon as practicable after the
12 date of enactment of this title, the Secretary shall estab-
13 lish, under the laws of the District of Columbia and in
14 accordance with this title, the Annie Dodge Wauneka and
15 Susan Laflesche-Picotte Native American Health and
16 Wellness Foundation.

17 “(b) PERPETUAL EXISTENCE.—The Foundation
18 shall have perpetual existence.

19 “(c) NATURE OF CORPORATION.—The Foundation—

20 “(1) shall be a charitable and nonprofit feder-
21 ally chartered corporation; and

22 “(2) shall not be an agency or instrumentality
23 of the United States.



1 “(d) PLACE OF INCORPORATION AND DOMICILE.—
2 The Foundation shall be incorporated and domiciled in the
3 District of Columbia.

4 “(e) DUTIES.—The Foundation shall—

5 “(1) encourage, accept, and administer private
6 gifts of real and personal property, and any income
7 from or interest in such gifts, for the benefit of, or
8 in support of, the mission of the Service;

9 “(2) undertake and conduct such other activi-
10 ties as will further the health and wellness activities
11 and opportunities of Native Americans; and

12 “(3) participate with and assist Federal, State,
13 and tribal governments, agencies, entities, and indi-
14 viduals in undertaking and conducting activities that
15 will further the health and wellness activities and op-
16 portunities of Native Americans.

17 “(f) COMMITTEE FOR THE ESTABLISHMENT OF THE
18 ANNIE DODGE WAUNKA AND SUSAN LAFLESCHE-
19 PICOTTE NATIVE AMERICAN HEALTH AND WELLNESS
20 FOUNDATION.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish the Committee for the Establishment of the
23 Annie Dodge Wauneka and Susan Laflesche-Picotte
24 Native American Health and Wellness Foundation



1 to assist the Secretary in establishing the Founda-
2 tion.

3 “(2) DUTIES.—Not later than 180 days after
4 the date of enactment of this section, the Committee
5 shall—

6 “(A) carry out such activities as are nec-
7 essary to incorporate the Foundation under the
8 laws of the District of Columbia, including act-
9 ing as incorporators of the Foundation;

10 “(B) ensure that the Foundation qualifies
11 for and maintains the status required to carry
12 out this section, until the Board is established;

13 “(C) establish the constitution and initial
14 bylaws of the Foundation;

15 “(D) provide for the initial operation of
16 the Foundation, including providing for tem-
17 porary or interim quarters, equipment, and
18 staff; and

19 “(E) appoint the initial members of the
20 Board in accordance with the constitution and
21 initial bylaws of the Foundation.

22 “(g) BOARD OF DIRECTORS.—

23 “(1) IN GENERAL.—The Board of Directors
24 shall be the governing body of the Foundation.



1 “(2) POWERS.—The Board may exercise, or
2 provide for the exercise of, the powers of the Foun-
3 dation.

4 “(3) SELECTION.—

5 “(A) IN GENERAL.—Subject to subpara-
6 graph (B), the number of members of the
7 Board, the manner of selection of the members
8 (including the filling of vacancies), and the
9 terms of office of the members shall be as pro-
10 vided in the constitution and bylaws of the
11 Foundation.

12 “(B) REQUIREMENTS.—

13 “(i) NUMBER OF MEMBERS.—The
14 Board shall have at least 11 members, who
15 shall have staggered terms.

16 “(ii) INITIAL VOTING MEMBERS.—The
17 initial voting members of the Board—

18 “(I) shall be appointed by the
19 Committee not later than 180 days
20 after the date on which the Founda-
21 tion is established; and

22 “(II) shall have staggered terms.

23 “(iii) QUALIFICATION.—The members
24 of the Board shall be United States citi-
25 zens who are knowledgeable or experienced



1 in Native American health care and related
2 matters.

3 “(C) COMPENSATION.—A member of the
4 Board shall not receive compensation for service
5 as a member, but shall be reimbursed for actual
6 and necessary travel and subsistence expenses
7 incurred in the performance of the duties of the
8 Foundation.

9 “(h) OFFICERS.—

10 “(1) IN GENERAL.—The officers of the Founda-
11 tion shall be—

12 “(A) a secretary, elected from among the
13 members of the Board; and

14 “(B) any other officers provided for in the
15 constitution and bylaws of the Foundation.

16 “(2) SECRETARY.—The secretary of the Foun-
17 dation shall serve, at the direction of the Board, as
18 the chief operating officer of the Foundation.

19 “(3) ELECTION.—The manner of election, term
20 of office, and duties of the officers of the Founda-
21 tion shall be as provided in the constitution and by-
22 laws of the Foundation.

23 “(i) POWERS.—The Foundation—



1 “(1) shall adopt a constitution and bylaws for
2 the management of the property of the Foundation
3 and the regulation of the affairs of the Foundation;

4 “(2) may adopt and alter a corporate seal;

5 “(3) may enter into contracts;

6 “(4) may acquire (through a gift or otherwise),
7 own, lease, encumber, and transfer real or personal
8 property as necessary or convenient to carry out the
9 purposes of the Foundation;

10 “(5) may sue and be sued; and

11 “(6) may perform any other act necessary and
12 proper to carry out the purposes of the Foundation.

13 “(j) PRINCIPAL OFFICE.—

14 “(1) IN GENERAL.—The principal office of the
15 Foundation shall be in the District of Columbia.

16 “(2) ACTIVITIES; OFFICES.—The activities of
17 the Foundation may be conducted, and offices may
18 be maintained, throughout the United States in ac-
19 cordance with the constitution and bylaws of the
20 Foundation.

21 “(k) SERVICE OF PROCESS.—The Foundation shall
22 comply with the law on service of process of each State
23 in which the Foundation is incorporated and of each State
24 in which the Foundation carries on activities.



1 “(1) LIABILITY OF OFFICERS, EMPLOYEES, AND
2 AGENTS.—

3 “(1) IN GENERAL.—The Foundation shall be
4 liable for the acts of the officers, employees, and
5 agents of the Foundation acting within the scope of
6 their authority.

7 “(2) PERSONAL LIABILITY.—A member of the
8 Board shall be personally liable only for gross neg-
9 ligence in the performance of the duties of the mem-
10 ber.

11 “(m) RESTRICTIONS.—

12 “(1) LIMITATION ON SPENDING.—Beginning
13 with the fiscal year following the first full fiscal year
14 during which the Foundation is in operation, the ad-
15 ministrative costs of the Foundation shall not exceed
16 10 percent of the sum of—

17 “(A) the amounts transferred to the Foun-
18 dation under subsection (o) during the pre-
19 ceding fiscal year; and

20 “(B) donations received from private
21 sources during the preceding fiscal year.

22 “(2) APPOINTMENT AND HIRING.—

23 “(A) IN GENERAL.—The appointment of
24 officers and employees of the Foundation shall
25 be subject to the availability of funds.



1 “(B) KNOWLEDGE OF RESERVATION GOV-
2 ERNANCE AND SOCIAL LIFE.—The Secretary
3 shall encourage the Foundation to hire individ-
4 uals who have an extensive knowledge of res-
5 ervation governance and social life.

6 “(3) STATUS.—A member of the Board or offi-
7 cer, employee, or agent of the Foundation shall not
8 by reason of association with the Foundation be con-
9 sidered to be an officer, employee, or agent of the
10 United States.

11 “(n) AUDITS.—The Foundation shall comply with
12 section 10101 of title 36, United States Code, as if the
13 Foundation were a corporation under part B of subtitle
14 II of that title.

15 “(o) FUNDING.—

16 “(1) AUTHORIZATION OF APPROPRIATIONS.—
17 There is authorized to be appropriated to carry out
18 subsection (e)(1) \$1,000,000 for each fiscal year, as
19 adjusted to reflect changes in the Consumer Price
20 Index for all-urban consumers published by the De-
21 partment of Labor.

22 “(2) TRANSFER OF DONATED FUNDS.—The
23 Secretary shall transfer to the Foundation funds
24 held by the Department of Health and Human Serv-
25 ices under the Act of August 5, 1954 (42 U.S.C.



1 2001 et seq.), if the transfer or use of the funds is
2 not prohibited by any term under which the funds
3 were donated.

4 **“SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.**

5 “(a) PROVISION OF SUPPORT BY SECRETARY.—Sub-
6 ject to subsection (b), during the 5-year period beginning
7 on the date on which the Foundation is established, the
8 Secretary—

9 “(1) may provide personnel, facilities, and other
10 administrative support services to the Foundation;

11 “(2) may provide funds to reimburse the travel
12 expenses of the members of the Board; and

13 “(3) shall require and accept reimbursements
14 from the Foundation for—

15 “(A) services provided under paragraph
16 (1); and

17 “(B) funds provided under paragraph (2).

18 “(b) REIMBURSEMENT.—Reimbursements accepted
19 under subsection (a)(3)—

20 “(1) shall be deposited in the Treasury of the
21 United States to the credit of the applicable appro-
22 priations account; and

23 “(2) shall be chargeable for the cost of pro-
24 viding services described in subsection (a)(1) and
25 travel expenses described in subsection (a)(2).



1 “(c) CONTINUATION OF CERTAIN SERVICES.—The
2 Secretary may continue to provide facilities and necessary
3 support services to the Foundation after the termination
4 of the 5-year period specified in subsection (a) if the facili-
5 ties and services—

6 “(1) are available; and

7 “(2) are provided on reimbursable cost basis.”.

8 (b) TECHNICAL AMENDMENTS.—The Indian Self-De-
9 termination and Education Assistance Act is amended—

10 (1) by redesignating title V (as added by sec-
11 tion 1302 of the American Indian Education Foun-
12 dation Act of 2000) (25 U.S.C. 458bbb et seq.) as
13 title VII;

14 (2) by redesignating sections 501, 502, and 503
15 (as added by section 1302 of the American Indian
16 Education Foundation Act of 2000) as sections 701,
17 702, and 703, respectively; and

18 (3) in subsection (a)(2) of section 702 and
19 paragraph (2) of section 703 (as redesignated by
20 paragraph (2)), by striking “section 501” and in-
21 serting “section 701”.



1 **Subtitle B—Rural and Underserved**
2 **Urban America Telehealth Pro-**
3 **grams**

4 **SEC. 711. INCREASING TYPES OF ORIGINATING TELE-**
5 **HEALTH SITES AND FACILITATING THE PRO-**
6 **VISION OF TELEHEALTH SERVICES ACROSS**
7 **STATE LINES.**

8 (a) INCREASING TYPES OF ORIGINATING SITES.—

9 Section 1834(m)(4)(C)(ii) of the Social Security Act (42
10 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the
11 end the following:

12 “(VI) A skilled nursing facility
13 (as defined in section 1819(a)).

14 “(VII) An assisted-living facility
15 (as defined by the Secretary).

16 “(VIII) A board-and-care home
17 (as defined by the Secretary).

18 “(IX) A county or community
19 health clinic (as defined by the Sec-
20 retary).

21 “(X) A community mental health
22 center (as described in section
23 1861(ff)(2)(B)).

24 “(XI) A facility operated by the
25 Indian Health Service or by an Indian



1 tribe, tribal organization, or an urban
2 Indian organization (as such terms
3 are defined in section 4 of the Indian
4 Health Care Improvement Act (25
5 U.S.C. 1603)) directly, or under con-
6 tract or other arrangement.

7 “(XII) A site in a State in which
8 the respective State medical board has
9 adopted a formal policy regarding li-
10 censing or certification requirements
11 for providers at distant sites who do
12 not have a license to practice medicine
13 at the originating site.”.

14 (b) EXPANDING ELIGIBILITY FOR REIMBURSE-
15 MENT.—Section 1834(m)(4)(C)(i)(I) of the Social Secu-
16 rity Act (42 U.S.C. 1395m(m)(4)(C)(i)(I)) is amended by
17 striking “rural”.

18 **SEC. 712. STRENGTHENING TELEHEALTH SERVICES IN**
19 **RURAL AND UNDERSERVED URBAN AMERICA.**

20 Subpart I of part D of title III of the Public Health
21 Service Act (42 U.S.C. 254b et seq.) is amended—

22 (1) in section 330L—

23 (A) by redesignating subsection (b) as sub-
24 section (c); and



1 (B) by inserting after subsection (a) the
2 following:

3 “(b) CONFERENCE.—Within 1 year of the date of en-
4 actment of the Telehealth Improvement Act of 2004, the
5 Secretary shall convene a conference of State licensing
6 boards, local telehealth projects, health care practitioners,
7 and patient advocates to promote interstate licensure for
8 telehealth projects.”; and

9 (2) by adding at the end the following:

10 **“SEC. 330M. INTEGRATIVE ELDERCARE TELEHEALTH DEM-**
11 **ONSTRATION PROJECT.**

12 “(a) PURPOSES.—The purposes of this section are to
13 encourage the creation of programs to—

14 “(1) evaluate the use of telehealth services in
15 an integrative eldercare setting;

16 “(2) eliminate fragmented service delivery while
17 promoting enhanced continuity of care and more
18 simplified access to services;

19 “(3) develop community-based options that pro-
20 mote patient independence and leverage telehealth
21 services and equipment to enable the use of the most
22 cost-effective, least restrictive care settings; and

23 “(4) promote access for elderly patients in rural
24 and underserved urban areas to improvements in
25 medical technology and training across an integrated



1 spectrum of care; and to make health care services
2 more flexible and responsive to the diverse and
3 changing needs of elderly patients in rural areas.

4 “(b) GRANTS AUTHORIZED.—

5 “(1) IN GENERAL.—The Director may award
6 grants to eligible providers for projects to dem-
7 onstrate how telehealth technologies can be used
8 through telehealth networks in rural areas, frontier
9 communities, and medically underserved areas, and
10 for medically underserved populations, to—

11 “(A) expand access to, coordinate, and im-
12 prove the quality of health care services;

13 “(B) improve and expand the training of
14 health care providers; and

15 “(C) expand and improve the quality of
16 health information available to health care pro-
17 viders, and patients and their families, for deci-
18 sionmaking.

19 “(2) GRANT PERIOD.—The Director shall
20 award grants under this subsection for a period of
21 up to 4 years.

22 “(3) NUMBER OF GRANTS.—Not to exceed 20
23 grants shall be awarded under this subsection, of
24 which at least ½ shall be dedicated to providing
25 services in rural communities.



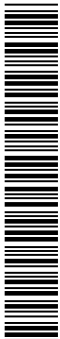
1 “(c) USE OF FUNDS.—Grants awarded pursuant to
2 subsection (b) may be used for activities including—

3 “(1) improving access to coordinated health
4 care services at the lowest intensity and resource
5 level of care consistent with quality health care serv-
6 ices and optimal patient outcomes, improving the
7 quality of such care, increasing patient satisfaction
8 with such care, and reducing the cost of such care
9 through advanced telecommunication technologies;

10 “(2) developing effective care management
11 practices and educational curricula to train health
12 care professionals, paraprofessionals, and caregivers,
13 including family members, and to increase the gen-
14 eral level of competency of such individuals through
15 such training; and

16 “(3) developing curricula to train health care
17 professionals, paraprofessionals, and caregivers, in-
18 cluding family members, serving integrative
19 eldercare patients in the use of telecommunications.

20 “(d) APPLICATIONS.—To be eligible to receive a
21 grant under subsection (b), an eligible provider, in con-
22 sultation with the appropriate State office of rural health
23 or another appropriate State entity, shall prepare and sub-
24 mit to the Director an application, at such time, in such



1 manner, and containing such information as the Director
2 may require, including—

3 “(1) a description of the project that the eligi-
4 ble entity will carry out using the funds provided
5 under the grant;

6 “(2) a description of the manner in which the
7 project funded under the grant will meet the health
8 care needs of rural or other populations to be served
9 through the project, or improve the access to serv-
10 ices of, and the quality of the services received by,
11 those populations;

12 “(3) evidence of local support for the project,
13 and a description of how the areas, communities, or
14 populations to be served will be involved in the devel-
15 opment and ongoing operations of the project;

16 “(4) a plan for sustaining the project after Fed-
17 eral support for the project has ended;

18 “(5) information on the source and amount of
19 non-Federal funds that the entity will provide for
20 the project;

21 “(6) information demonstrating the long-term
22 viability of the project, and other evidence of institu-
23 tional commitment of the entity to the project;

24 “(7) in the case of an application for a project
25 involving a telehealth network, information dem-



1 onstrating how the project will promote the integra-
2 tion of telehealth technologies into the operations of
3 health care providers, to avoid redundancy, and im-
4 prove access to and the quality of care; and

5 “(8) other such information as the Director de-
6 termines to be appropriate.

7 “(e) REPORT.—

8 “(1) FINAL REPORT.—Not later than 9 months
9 after the date of termination of the last grant to be
10 awarded under this section, the Director shall sub-
11 mit to Congress a final report—

12 “(A) describing the results of the programs
13 funded by grants awarded pursuant to this sec-
14 tion; and

15 “(B) evaluating the impact of the use of
16 telehealth services in an integrative eldercare
17 setting on—

18 “(i) access to care for patients served
19 by integrative eldercare programs; and

20 “(ii) the quality of, patient satisfac-
21 tion with, and the cost of, such care.

22 “(2) ENSURING ACCESS TO QUALITY CARE.—In
23 conducting the evaluation under paragraph (1)(B),
24 the Director shall—



1 “(A) give special consideration to the im-
2 pact of programs funded under this section on
3 face-to-face access to medical providers; and

4 “(B) develop specific measures to evaluate
5 the quality of care provided to those partici-
6 pating in such programs to ensure that tele-
7 health augments the plan of care.

8 “(f) ELIGIBLE PROVIDER.—The term ‘eligible pro-
9 vider’ means a consortia of home and facility-based care
10 providers that includes providers from no less than 2 of
11 the following:

12 “(1) An adult congregate care facility.

13 “(2) A continuing care retirement community.

14 “(3) An assisted living facility.

15 “(4) An Alzheimer’s facility.

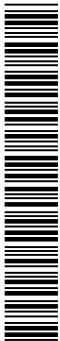
16 “(5) An institutional hospice facility.

17 “(6) A residential care facility.

18 “(7) An adult foster home.

19 “(8) A State-licensed nursing home, including a
20 skilled nursing facility, an intermediate care facility,
21 licensed home health provider or other health care
22 provider that the Director deems appropriate and
23 consistent with the purposes of this section.

24 “(g) DEFINITIONS.—In this section:



1 “(1) DIRECTOR; OFFICE.—The terms ‘Director’
2 and ‘Office’ mean the Director of the Office for the
3 Advancement of Telehealth and the Office for the
4 Advancement of Telehealth.

5 “(2) INTEGRATIVE ELDERCARE.—The term ‘in-
6 tegrative eldercare’ includes case management and
7 coordination of care for elderly patients recovering
8 from acute illness or coping with chronic disease at
9 the lowest intensity and resource level of care con-
10 sistent with quality health care services and optimal
11 patient outcomes.

12 “(3) TELEHEALTH SERVICES.—The term ‘tele-
13 health services’ means services provided through
14 telehealth technologies.

15 “(4) TELEHEALTH TECHNOLOGIES.—The term
16 ‘telehealth technologies’ means technologies relating
17 to the use of electronic information, and tele-
18 communications technologies, to support and pro-
19 mote, at a distance, health care, patient and profes-
20 sional health-related education, health administra-
21 tion, and public health.

22 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to the Office for the Ad-
24 vancement of Telehealth to carry out this section



1 \$30,000,000 for fiscal year 2006 and such sums as may
2 be necessary for each of fiscal years 2007 through 2009.

3 **“SEC. 330N. AMERICAN INDIAN AND ALASKA NATIVE TELE-**
4 **HEALTH DEMONSTRATION PROJECT.**

5 “(a) PURPOSE.—The purpose of this section is to
6 evaluate the use of telehealth services in areas under the
7 jurisdiction of Indian tribes or tribal organizations, includ-
8 ing efforts to develop more effective case management for
9 chronic and acute disease and preventive health care pro-
10 grams.

11 “(b) GRANTS AUTHORIZED.—

12 “(1) IN GENERAL.—The Director may award
13 grants to eligible providers, individually or as part of
14 a network of eligible providers, for the provision of
15 telehealth services to improve patient care, prevent
16 health care complications, improve patient outcomes,
17 and achieve efficiencies in the delivery of care to pa-
18 tients who reside in areas under the jurisdiction of
19 Indian tribes or tribal organizations.

20 “(2) GRANT PERIOD.—The Director shall
21 award grants under this section for a period of up
22 to 4 years.

23 “(3) NUMBER OF GRANTS.—Not to exceed 20
24 grants shall be awarded under this section, of which



1 at least 1/2 shall be dedicated to providing services
2 in rural communities.

3 “(c) USE OF FUNDS.—Grants awarded under this
4 section may be used for activities including—

5 “(1) improving access to care for home care pa-
6 tients served by eligible providers, improving the
7 quality of such care, increasing patient satisfaction
8 with such care, and reducing the cost of such care
9 through advanced telecommunication technologies;

10 “(2) developing effective telehealth management
11 practices and educational curricula to train health
12 professionals and paraprofessionals and increase
13 their general level of competency through such train-
14 ing; and

15 “(3) developing curricula to train health care
16 professionals and paraprofessionals serving patients
17 of eligible providers in the use of telecommuni-
18 cations.

19 “(d) COLLABORATION.—The Director shall ensure
20 that eligible providers receiving grants under this section
21 collaborate to enable comparisons across programs and to
22 share relevant, de-identified information to better facili-
23 tate program performance evaluation.

24 “(e) APPLICATIONS.—To be eligible to receive a grant
25 under subsection (b), an eligible entity, in consultation



1 with the appropriate State office of rural health or another
2 appropriate State entity, shall prepare and submit to the
3 Director an application, at such time, in such manner, and
4 containing such information as the Director may require,
5 including—

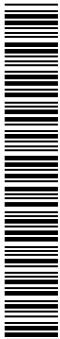
6 “(1) a description of the project that the eligi-
7 ble entity will carry out using the funds provided
8 under the grant;

9 “(2) a description of the manner in which the
10 project funded under the grant will meet the health
11 care needs of rural or other populations to be served
12 through the project, or improve the access to serv-
13 ices of, and the quality of the services received by,
14 those populations;

15 “(3) evidence of local support for the project,
16 and a description of how the areas, communities, or
17 populations to be served will be involved in the devel-
18 opment and ongoing operations of the project;

19 “(4) a plan for sustaining the project after Fed-
20 eral support for the project has ended;

21 “(5) information on the source and amount of
22 non-Federal funds that the entity will provide for
23 the project;



1 “(6) information demonstrating the long-term
2 viability of the project, and other evidence of institu-
3 tional commitment of the entity to the project;

4 “(7) in the case of an application for a project
5 involving a telehealth network, information dem-
6 onstrating how the project will promote the integra-
7 tion of telehealth technologies into the operations of
8 health care providers, to avoid redundancy, and im-
9 prove access to and the quality of care; and

10 “(8) other such information as the Director de-
11 termines to be appropriate.

12 “(f) REPORT.—

13 “(1) FINAL REPORT.—Not later than 9 months
14 after the date of termination of the last grant to be
15 awarded under this section, the Director shall sub-
16 mit to Congress a final report—

17 “(A) describing the results of the programs
18 funded by grants awarded pursuant to this sec-
19 tion; and

20 “(B) evaluating the impact of telehealth
21 services in an institutional long-term care set-
22 ting on—

23 “(i) access to care for patients of eli-
24 gible providers; and



1 “(ii) the quality of, patient satisfac-
2 tion with, and the cost of, such care.

3 “(2) ENSURING ACCESS TO QUALITY CARE.—In
4 conducting the evaluation under paragraph (1)(B),
5 the Director shall—

6 “(A) give special consideration to the im-
7 pact of programs funded under this section on
8 face-to-face access to medical providers; and

9 “(B) develop specific measures to evaluate
10 the quality of care provided to those partici-
11 pating in such programs to ensure that tele-
12 medicine augments the plan of care.

13 “(g) DEFINITIONS.—In this section:

14 “(1) DIRECTOR; OFFICE.—The terms ‘Director’
15 and ‘Office’ mean the Director of the Office for the
16 Advancement of Telehealth and the Office for the
17 Advancement of Telehealth.

18 “(2) ELIGIBLE PROVIDER.—The term ‘eligible
19 provider’ includes any public or private nonprofit
20 health care provider a majority of whose patient
21 practice is Native American or any Indian tribe or
22 tribal organization that provides health care services
23 for its members.

24 “(3) INDIAN TRIBE.—The term ‘Indian tribe’
25 has the meaning given such term in section 4 of the



1 Indian Self-Determination and Education Assistance
2 Act (25 U.S.C. 450b).

3 “(4) NATIVE AMERICAN.—The term ‘Native
4 American’ means a member of an Indian tribe, a
5 Native Hawaiian (as defined in section 338K(c)), or
6 a Native American Pacific Islander.

7 “(5) NATIVE AMERICAN PACIFIC ISLANDER.—
8 The term ‘Native American Pacific Islander’ means
9 an individual who is indigenous to a United States
10 territory or possession located in the Pacific Ocean.

11 “(6) TRIBAL ORGANIZATION.—The term ‘tribal
12 organization’ has the meaning given such term in
13 section 4 of the Indian Self-Determination and Edu-
14 cation Assistance Act (25 U.S.C. 450b).

15 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section
17 \$30,000,000 for fiscal year 2006 and such sums as may
18 be necessary for each of fiscal years 2007 through 2009.

19 **“SEC. 330O. ORAL HEALTH TELEHEALTH DEMONSTRATION**
20 **PROJECT.**

21 “(a) PURPOSE.—The purpose of this section is to
22 evaluate the use of telehealth services to expand access
23 to oral health services and improve oral health outcomes
24 among rural and underserved urban patients.

25 “(b) GRANTS AUTHORIZED.—



1 “(1) IN GENERAL.—The Director is authorized
2 to award competitive grants to eligible providers, in-
3 dividually or as part of a network of eligible pro-
4 viders, for the provision of oral health services to im-
5 prove patient care, prevent health care complica-
6 tions, improve patient outcomes, and achieve effi-
7 ciencies in the delivery of oral health care to patients
8 who reside in rural areas.

9 “(2) GRANT PERIOD.—The Director shall
10 award grants under this section for a period of up
11 to 4 years.

12 “(3) NUMBER OF GRANTS.—The number of
13 grants awarded under this section shall not exceed
14 10 grants.

15 “(c) USE OF FUNDS.—Grants awarded pursuant to
16 subsection (b) may be used for activities including—

17 “(1) improving access to care for rural and un-
18 derserved urban patients served by eligible providers,
19 improving the quality of that care, increasing patient
20 satisfaction with that care, and reducing the cost of
21 that care through advanced telecommunication tech-
22 nologies;

23 “(2) developing effective oral telehealth care
24 management practices and educational curricula to
25 train oral health professionals and paraprofessionals



1 and increase their general level of competency
2 through that training; and

3 “(3) developing curricula to train health care
4 professionals and paraprofessionals, serving rural
5 and underserved urban patients in the use of tele-
6 communications.

7 “(d) APPLICATIONS.—To be eligible to receive a
8 grant under subsection (b), an eligible entity, in consulta-
9 tion with the appropriate State office of rural health or
10 another appropriate State entity, shall prepare and submit
11 to the Director an application, at such time, in such man-
12 ner, and containing such information as the Director may
13 require, including—

14 “(1) a description of the project that the eligi-
15 ble entity will carry out using the funds provided
16 under the grant;

17 “(2) a description of the manner in which the
18 project funded under the grant will meet the health
19 care needs of rural or other populations to be served
20 through the project, or improve the access to serv-
21 ices of, and the quality of the services received by,
22 those populations;

23 “(3) evidence of local support for the project,
24 and a description of how the areas, communities, or



1 populations to be served will be involved in the devel-
2 opment and ongoing operations of the project;

3 “(4) a plan for sustaining the project after Fed-
4 eral support for the project has ended;

5 “(5) information on the source and amount of
6 non-Federal funds that the entity will provide for
7 the project;

8 “(6) information demonstrating the long-term
9 viability of the project, and other evidence of institu-
10 tional commitment of the entity to the project;

11 “(7) in the case of an application for a project
12 involving a telehealth network, information dem-
13 onstrating how the project will promote the integra-
14 tion of telehealth technologies into the operations of
15 health care providers, to avoid redundancy, and im-
16 prove access to and the quality of care; and

17 “(8) other such information as the Director de-
18 termines to be appropriate.

19 “(e) REPORT.—

20 “(1) FINAL REPORT.—Not later than 9 months
21 after the date of termination of the last grant to be
22 awarded under this section, the Director shall sub-
23 mit to Congress a final report—



1 “(A) describing the results of the programs
2 funded by grants awarded pursuant to this sec-
3 tion; and

4 “(B) including an evaluation of the impact
5 of the use of oral telehealth services on—

6 “(i) access to oral health care for
7 rural patients; and

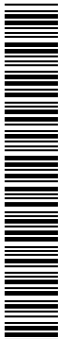
8 “(ii) the quality of, patient satisfac-
9 tion with, and the cost of, that care.

10 “(2) ENSURING ACCESS TO QUALITY CARE.—In
11 conducting the evaluation under paragraph (1)(B),
12 the Director shall—

13 “(A) give special consideration to the im-
14 pact of programs funded under this section on
15 face-to-face access to medical providers; and

16 “(B) develop specific measures to evaluate
17 the quality of care provided to those partici-
18 pating in such programs to ensure that tele-
19 medicine augments the plan of care.

20 “(f) DEFINITION OF ELIGIBLE PROVIDER.—In this
21 section the term ‘eligible provider’ includes dentists,
22 periodontists, orthodontists, dental and oral health clinics,
23 and schools of dentistry and oral health, where a majority
24 of the patient population resides in a rural area, and may



1 include other rural oral health providers that the Director
2 deems appropriate.

3 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 \$30,000,000 for fiscal year 2006 and such sums as may
6 be necessary for each of fiscal years 2007 through 2009.”.

7 **SEC. 713. JOINT WORKING GROUP ON TELEHEALTH.**

8 (a) IN GENERAL.—

9 (1) REPRESENTATION OF RURAL AREAS.—The
10 Secretary of Health and Human Services shall es-
11 tablish, within the Health Resources and Services
12 Administration Office for the Advancement of Tele-
13 health, and under the leadership of the Director of
14 the Office for the Advancement of Telehealth, a
15 Joint Working Group on Telehealth. In establishing
16 such Group, the Secretary shall ensure that all rel-
17 evant Federal agencies are represented and that
18 input from relevant industry groups, including rep-
19 resentatives of rural areas and medically under-
20 served areas, is fully considered.

21 (2) MISSION.—The mission of the Joint Work-
22 ing Group on Telehealth is—

23 (A) to identify, monitor, and coordinate
24 Federal telehealth projects, data sets, and pro-
25 grams;



1 (B) to analyze—

2 (i) how telehealth systems are expand-
3 ing access to health care services, edu-
4 cation, and information;

5 (ii) the clinical, educational, or admin-
6 istrative efficacy and cost-effectiveness of
7 telehealth applications; and

8 (iii) the quality of the telehealth serv-
9 ices delivered; and

10 (C) to make further recommendations for
11 coordinating Federal and State efforts to in-
12 crease access to health services, education, and
13 information in rural and medically underserved
14 areas.

15 (3) ANNUAL REPORTS.—Not later than 2 years
16 after the date of enactment of this Act, and each
17 January 1 thereafter, the Joint Working Group on
18 Telehealth shall submit to Congress a report on the
19 status of the Group’s mission and the state of the
20 telehealth field generally.

21 (b) REPORT SPECIFICS.—The annual report required
22 under subsection (a)(3) shall provide—

23 (1) an analysis of—

24 (A) the matters described in subsection

25 (a)(2)(B);



1 (B) Federal activities with respect to tele-
2 health; and

3 (C) the process of the Joint Working
4 Group on Telehealth's efforts to coordinate
5 Federal telehealth programs; and

6 (2) recommendations for a coordinated Federal
7 strategy to increase health care access through tele-
8 health.

9 (c) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to enable the Joint Working Group on Tele-
12 health to carry out this section.

13 **TITLE VIII—MISCELLANEOUS** 14 **PROVISIONS**

15 **SEC. 801. DEFINITIONS.**

16 For purposes of this Act (including the amendments
17 made by this Act other than the amendments made by
18 subtitles A through G of title I):

19 (1) APPROPRIATE HEALTHCARE SERVICES.—

20 The term “appropriate healthcare services” includes
21 services or treatments to address physical, mental,
22 and behavioral diseases, conditions, or syndromes.

23 The definition contained in this paragraph shall not
24 apply for purposes of sections 206 and 606.



1 (2) HEALTH.—The term “health” includes oral
2 health and dental hygiene.

3 (3) HEALTH PROFESSION.—The term “health
4 profession” includes mental and behavioral health
5 professions.

6 (4) HISPANIC.—The term “Hispanic” means
7 individuals whose origin is Mexican, Puerto Rican,
8 Cuban, Central or South American, or any other
9 Spanish-speaking country.

10 (5) INDIAN.—The term “Indian”, unless other-
11 wise designated, means any person who is a member
12 of an Indian tribe

13 (6) INDIAN TRIBE.—The term “Indian tribe”
14 means any Indian tribe, band, nation, or other orga-
15 nized group or community, including any Alaska Na-
16 tive village or group or regional or village corpora-
17 tion as defined in or established pursuant to the
18 Alaska Native Claims Settlement Act (85 Stat. 688)
19 (43 U.S.C. 1601 et seq.), which is recognized as eli-
20 gible for the special programs and services provided
21 by the United States to Indians because of their sta-
22 tus as Indians.

23 (7) LIMITED ENGLISH PROFICIENT.—The term
24 “limited English proficient” with respect to an indi-
25 vidual means an individual who cannot speak, read,



1 write, or understand the English language at a level
2 that permits them to interact effectively with clinical
3 or nonclinical staff at a healthcare organization.

4 (8) MINORITY.—

5 (A) IN GENERAL.—The terms “minority”
6 and “minorities” refer to individuals from a mi-
7 nority group.

8 (B) POPULATIONS.—The term “minority”,
9 with respect to populations, refers to racial and
10 ethnic minority groups.

11 (9) MINORITY GROUP.—The term “minority
12 group” has the meaning given the term “racial and
13 ethnic minority group”.

14 (10) RACIAL AND ETHNIC MINORITY GROUP.—
15 The term “racial and ethnic minority group” means
16 American Indians and Alaska Natives, African
17 Americans (including Blacks), Asian Americans,
18 Hispanics (including Latinos), and Native Hawai-
19 ians and other Pacific Islanders.

20 (11) SECRETARY.—The term “Secretary”
21 means the Secretary of Health and Human Services.

22 (12) STATE.—The term “State” means each of
23 the several states, the District of Columbia, the
24 Commonwealth of Puerto Rico, the Indian tribes,



1 the Virgin Islands, Guam, American Samoa, and the
2 Commonwealth of the Northern Mariana Islands.

3 (13) TRIBAL ORGANIZATION.—The term “tribal
4 organization” means the elected governing body of
5 any Indian tribe or any legally established organiza-
6 tion of Indians which is controlled by one or more
7 such bodies or by a board of directors elected or se-
8 lected by one or more such bodies (or elected by the
9 Indian population to be served by such organization)
10 and which includes the maximum participation of
11 Indians in all phases of its activities.

12 (14) UNDERREPRESENTED MINORITY.—The
13 terms “underrepresented minority” and “underrep-
14 resented minorities” refer to individuals who are
15 members of racial or ethnic minority groups that are
16 underrepresented in the health professions relative
17 to their numbers in the general population.

18 (15) UNDERSERVED POPULATIONS.—The term
19 “underserved population” means the population of
20 an urban or rural area designated by the Secretary
21 as an area with a shortage of personal health serv-
22 ices or a population group designated by the Sec-
23 retary as having a shortage of such services.



1 **SEC. 802. DAVIS-BACON ACT.**

2 All laborers and mechanics employed by contractors
3 or subcontractors in the performance of construction work
4 financed in whole or in part with assistance under this
5 Act (or an amendment made by this Act), including cap-
6 ital financing assistance, or grants or loan guarantees
7 from the Safety Net Infrastructure Trust Fund (estab-
8 lished under section 2952C of the Public Health Service
9 Act), shall be paid wages at rates not less than those pre-
10 vailing on similar work in the locality involved as deter-
11 mined by the Secretary of Labor in accordance with sub-
12 chapter IV of chapter 31 of title 40, United States Code
13 (commonly referred to as the Davis-Bacon Act). The Sec-
14 retary of Labor shall have, with respect to such labor
15 standards, the authority and functions set forth in Reor-
16 ganization Plan Numbered 14 of 1950 (15 F.R. 3176; 64
17 Stat 1267) and section 3145 of title 40, United States
18 Code.

